Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

MEDICAL ASSISTANCE ADMINISTRATION

Nondurable Medical Supplies and Equipment (MSE)

Billing Instructions

Chapter 388-543 WAC

October 2003

About this publication

This publication supersedes all previous Nondurable Medical Supplies and Equipment (MSE) publications. These billing instructions are for specific disposable/nonreusable supplies. The following programs have individual billing instructions:

- Wheelchairs & Durable Medical Equipment and Supplies
- Medical Nutrition
- Infusion Therapy
- Prosthetic/Orthotic Devices and Supplies

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Table of Contents

Table of Contents (cont.)

Important Contacts

A provider may use MAA's toll-free lines for questions regarding its programs; however, MAA's response is based solely on the information provided to the [MAA] representative at the time of the call or inquiry, and in no way exempts a provider from following the rules and regulations that govern MAA's programs. [WAC 388-502-0020(2)].

Where do I call for information on becoming a DSHS provider, submitting a change of address or ownership, or to ask questions about the status of a provider application?

Call the toll-free line:
(866) 545-0544

Where do I send my claims?

Division of Program Support
PO Box 9247
Olympia WA 98507-9247

How do I request prior authorization and a limitation extension?

All authorization issues, questions or comments should be addressed to:

Write/Call:
Division of Medical Management
Durable Medical Equipment
PO Box 45506
Olympia, WA 98504-5506
(800) 292-8064
(360) 586-1471 Fax

Where do I address reimbursement issues, questions, or comments?

Rates Analysis Section
Division of Business and Finance
PO Box 45510
Olympia, WA 98504-5510
Fax: (360) 753-9152

Who do I contact if I have questions regarding…

Policy, payments, denials, general questions regarding claims processing, Healthy Options, or to request billing instructions?

Medical Assistance Customer Service Center
(800) 562-6188

Private insurance or third-party liability, other than Healthy Options?

Coordination of Benefits Section
(800) 562-6136

Electronic Billing?

Electronic Media Information
(360) 725-1267

Internet Billing?

http://maa.dshs.wa.gov/ecs

How do I obtain copies of billing instructions or numbered memoranda?

Go to MAA's web site at: http://maa.dshs.wa.gov, Provider Publications/Fee Schedules link.

How can I request that equipment/supplies be added to the "covered" list in these billing instructions?

Write/Call:

Division of Medical Management
DME Program Management Unit
PO Box 45506
Olympia, WA 98504-5506
(800) 292-8064
(360) 586-5299 Fax

Definitions

This section defines terms, abbreviations, and acronyms used in this billing instruction.

Base Year – The year of the data source used in calculating prices. [WAC 388-543-1000]

By Report (BR) – A method of reimbursement for covered items, procedures, and services for which the department has no set maximum allowable fees. [WAC 388-543-1000]

Client - An individual who has been determined eligible to receive medical or health care services under any MAA program.

Code of Federal Regulations (CFR) - Rules adopted by the federal government.

Community Services Office (CSO) - An office of the department's economic services administration that administers social and health services at the community level

Core Provider Agreement - The basic contract between MAA and an entity providing services to eligible clients. The core provider agreement outlines and defines terms of participation in medical assistance programs.

Date of Delivery – The date the client actually took physical possession of an item or equipment. [WAC 388-543-1000]

Department - The state Department of Social and Health Services [DSHS]. [WAC 388-500-0005]

Disposable Supplies – Supplies that may be used once, or more than once, but are time limited. [WAC 388-543-1000]

Durable Medical Equipment (DME) – Equipment that:

- Can withstand repeated use;
- Is primarily and customarily used to serve a medical purpose;
- Generally is not useful to a person in the absence of illness or injury; and
- Is appropriate for use in the client's place of residence.

[WAC 388-543-1000]

Expedited Prior Authorization – The process for obtaining authorization for selected durable medical equipment, and related supplies, prosthetics, orthotics, medical supplies and related services, in which providers use a set of numeric codes to indicate to MAA which acceptable indications/conditions/MAA-defined criteria are applicable to a particular request for DME authorization. [WAC 388-543-1000]

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Explanation of Medicare Benefits (EOMB) – A federal report generated for Medicare providers displaying transaction information regarding Medicare claims processing and payments.

Fee-for-Service – The general payment method MAA uses to reimburse for covered medical services provided to clients, except those services covered under MAA's prepaid managed care programs. [WAC 388-543-1000]

Health Care Financing Administration Common Procedure Coding System (HCPCS) – A coding system established by the Health Care Financing Administration to define services and procedures. [WAC 388-543-1000]

Healthy Options – The name of the Washington State, Medical Assistance Administration's managed care program.

Limitation Extension – A process for requesting and approving covered services and reimbursement that exceeds a coverage limitation (quantity, frequency, or duration) set in WAC, billing instructions, or numbered memoranda. Limitation extensions require prior authorization. [WAC 388-543-1000]

Managed Care - A comprehensive system of coordinated medical and health care delivery including preventive, primary, specialty, and ancillary health services. [WAC 388-538-050]

Maximum Allowable - The maximum dollar amount that MAA will reimburse a provider for specific services, supplies, and equipment.

Medicaid - The state and federally funded Title XIX program under which medical care is provided to persons eligible for the:

- Categorically needy program; or
- Medically needy program.

Medical Assistance Administration (MAA) - The administration within DSHS authorized by the secretary to administer the acute care portion of Title XIX Medicaid, Title XXI state-children's health insurance program (S-CHIP), Title XVI, and the state-funded medical care programs, with the exception of certain nonmedical services for persons with chronic disabilities.

Medical Identification card(s) – The document MAA uses to identify a client's eligibility for a medical program. These cards were formerly known as medical assistance identification (MAID) cards.

Medically Necessary - A term for describing [a] requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. [WAC 388-500-0005]

Medical Supplies – Supplies that are:

- Primarily and customarily used to service a medical purpose; and
- Generally not useful to a person in the absence of illness or injury. [WAC 388-543-1000]

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare has two parts:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.
- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare. [WAC 388-500-0005]

Nonreusable Supplies – Supplies that are used only once and then are disposed of. [WAC 388-543-1000]

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each MAA client consisting of:

- First and middle initials (a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Personal or Comfort Item – An item or service that primarily serves the comfort or convenience of the client. [WAC 388-543-1000]

Plan of Care (POC) – (Also known as "plan of treatment" [POT]). A written plan of care that is established and periodically reviewed and signed by both a physician and a home health agency provider, that describes the home health care to be provided at the client's residence. [WAC 388-551-2010]

Prior Authorization – A process by which clients or providers must request and receive MAA approval for certain medical equipment and related supplies, prosthetics, orthotics, medical supplies and related services, based on medical necessity, before the services are provided to clients, as a precondition for provider reimbursement. Expedited prior authorization and limitation extension are types of prior authorization. Also see WAC 388-501-0165. (WAC 388-543-1000)

Provider - Any person or organization that has a signed contract or core provider agreement with DSHS to provide services to eligible clients.

Remittance and status report (RA) - A report produced by Medicaid Management Information System (MMIS), MAA's claims processing system, that provides detailed information concerning submitted claims and other financial transactions.

Resource Based Relative Value Scale (RBRVS) – A scale that measures the relative value of a medical service or intervention, based on amount of physician resources involved. [WAC 388-543-1000]

Reusable Supplies – Supplies that are to be used more than once. [WAC 388-543-1000]

Revised Code of Washington (RCW) - Washington State laws.

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical program client. [WAC 388-500-0005]

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.

Usual and Customary Charge – The amount the provider typically charges to 50% or more of his or her non-Medicaid clients, including clients with other third-party coverage. [WAC 388-543-1000]

Washington Administrative Code (WAC) - Codified rules of the state of Washington.

About the Program

What is the purpose of the Nondurable Medical Supplies and Equipment Program?

[Refer to WAC 388-543-1100 and 388-543-2800 (4)]

The Medical Assistance Administration's (MAA) Nondurable Medical Supplies and Equipment (MSE) Program is designed to allow eligible MAA clients to purchase medically necessary MSE that is not included in other reimbursements, such as inpatient hospital Diagnosis Related Group (DRG), nursing facility daily rate, Health Maintenance Organization (HMO), or managed health care programs. The federal government considers MSE as optional services under the Medicaid program, except when:

- Prescribed as an integral part of an approved plan of treatment under the Home Health Program; or
- Required under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program.

MAA may reduce or eliminate coverage for optional services, consistent with legislative appropriations.

MAA categorizes MSE as follows (see section E, *Authorization* for further information about specific limitations and requirements for prior authorization and expedited prior authorization):

- Antiseptics and germicides;
- Bandages, dressing, and tapes;
- Blood monitoring/testing supplies;
- Braces, belts, and supportive devices;
- Decubitus care products;
- Ostomy supplies;
- Pregnancy-related testing kits and nursing equipment supplies;
- Supplies associated with transcutaneous electrical nerve stimulators (TENS);
- Syringes and needles;
- Urological supplies (e.g., diapers, urinary retention catheters, pant liners, and doublers); and
- Miscellaneous supplies.

Which providers may be reimbursed by MAA for providing MSE? [Refer to WAC 388-543-1200]

- MAA requires a provider who supplies MSE and related services to an MAA client to meet all of the following:

  - ✓ Have a core provider agreement with MAA;
  - ✓ Have the proper business license;
  - ✓ Have appropriately trained qualified staff; and
  - ✓ Be certified, licensed and/or bonded if required, to perform the services billed to MAA.

- MAA may reimburse qualified providers for MSE, repairs, and related services on a fee-for-service (FFS) basis. MAA reimburses:

  - ✓ MSE providers for non-DME and related repair services;
  - ✓ Medical equipment dealers, pharmacies, and home health agencies under their medical vendor provider number for medical supplies, subject to the limitations in this billing instruction; and
  - ✓ Physicians who provide medical equipment and supplies in the physician's office. MAA may pay separately for medical supplies, subject to the provisions in MAA's Resource Based Relative Value Scale (RBRVS) fee schedule.

- MAA terminates from Medicaid participation any provider who violates program regulations and policies, as described in WAC 388-502-0020.

What about MSE provided in a physician's office?

[Refer to WAC 388-543-3000]

MAA does not pay an MSE provider for medical supplies used in conjunction with a physician office visit. As stated in the RBRVS fee schedule, MAA pays the office physician for these supplies, when it is appropriate.

Client Eligibility

Who is eligible? [Refer to Chapter 388-529 WAC]

Clients presenting Medical Identification cards with the following identifiers* are eligible for MSE:

Medical Program Identifier	Medical Program
CNP	Categorically Needy Program
CNP - CHIP	Categorically Needy Program - Children's Health Insurance Program
GA-U **No Out of State Care**	General Assistance - Unemployable
LCP - MNP	Limited Casualty Program-Medically Needy Program
MNP - QMB	Medically Needy Program-Qualified Medicare Beneficiaries – These clients are dual eligible (Medicare/Medicaid)

Limitations

Clients presenting Medical Identification cards with the following identifiers are eligible only for Emergency Contraceptive Pill (ECP) counseling under the MSE program.

Medical Program Identifier	Medical Program
Family Planning Only	Family Planning Only
TAKE CHARGE	TAKE CHARGE

☞ ***Note:** To provide clarification as a result of significant inquiries, clients presenting Medical Identification cards with the following identifier are not eligible for MSE:

- ✓ **QMB-Medicare Only** (Qualified Medicare Beneficiary-Medicare Only).

Are clients enrolled in an MAA managed care plan eligible?

[Refer to WAC 388-538-060 and 095]

YES! Clients with an identifier in the HMO column on their Medical Identification card are enrolled in one of MAA's managed care plans. All services must be requested directly through the client's Primary Care Provider (PCP). Clients can contact their plan by calling the telephone number located on their Medical Identification card.

All medical services covered under a managed health care plan must be obtained by the client through designated facilities or providers. The managed care plan is responsible for:

- Payment of covered services; and
- Payment of services referred by a provider participating with the plan to an outside provider.

MAA does not cover medical equipment and/or services provided to a client who is enrolled in an MAA-contracted managed care plan, but did not use one of the plan's participating provider. [WAC 388-543-1400 (9)]

> ☞ **Note:** To prevent billing denials, please check the client's Medical Identification card prior to scheduling services and at the time of the service and make sure proper authorization or referral is obtained from the plan.

Primary Care Case Manager/Management (PCCM)

For the client who has chosen to obtain care with a PCCM, the identifier in the HMO column is "PCCM." These clients must obtain or be referred for services via the PCCM. The PCCM is responsible for coordination of care just like the PCP would be in a plan setting. Please refer to the client's Medical Identification card for the PCCM. (See the *Billing* section for further information.)

> ☞ **Note:** To prevent billing denials, please check the client's Medical Identification card prior to scheduling services and at the time of the service and make sure proper authorization or referral is obtained from the PCCM.

Coverage/Limitations

What is covered? [Refer to WAC 388-543-1100]

The Medical Assistance Administration (MAA) covers the following subject to the provisions of this billing instruction:

- Equipment and supplies prescribed in accordance with an approved plan of treatment under the home health program;
- Disposable/nonreusable supplies; and
- Compliance packaging.

☞ **Note:** For a complete listing of covered medical equipment and related supplies, refer to the *Fee Schedule* section.

What are the general conditions of coverage?

MAA covers the services listed above only when all of the following apply. The services must be:

- Medically necessary (see *Definitions* section). The provider or client must submit to MAA sufficient objective evidence to establish medical necessity. Information used to establish medical necessity includes, but is not limited to, the following:

  ✓ A physiological description of the client's disease, injury, impairment, or other ailment, and any changes in the client's condition written by the prescribing physician, licensed prosthetist and/or orthotist, physical therapist, occupational therapist, or speech therapist; or

  ✓ Video and/or photograph(s) of the client demonstrating the impairments and the client's ability to use the requested equipment, when applicable.

- Within the scope of an eligible client's medical care program (see *Client Eligibility* section);

- Within accepted medical or physical medicine community standards of practice;

- Prior authorized (see section E, *Prior Authorization*);

- Prescribed by a physician or other licensed practitioner of the healing arts and are within the scope of his or her practice as defined by state law. The prescription must state the specific item or service requested, diagnosis, prognosis, estimated length of need (weeks or months, not to exceed six months before being reevaluated), and quantity; and

- Billed to the department as the payor of last resort only. For example, MAA does not pay first and then collect from Medicare second.

☞ **Note:** The evaluation of a By Report (BR) item, procedure, or service for its medical appropriateness and reimbursement value is on a case-by-case basis.

What are other specific conditions of coverage?

• Disposable/Nonreusable Supplies

Most disposable/nonreusable supplies do not require prior approval; however, they must be medically necessary and the least costly alternative. When providers do not bill the least costly alternative, they must keep medical justification from the prescribing provider in their files to justify the more expensive item.

☞ **Note:** Billing provisions are limited to a one-month supply only.

☞ **Note:** For a complete list of program limitations, refer to the *Fee Schedule*.

• Clients Residing in a Nursing Facility

MAA reimburses for supplies required for nursing facility resident care through the nursing facility fixed per diem rate except for the following, which are reimbursed separately:

✓ Supplies or services replacing all or parts of the function of a permanently impaired or malfunctioning internal body organ:

- ➢ Colostomy (and other ostomy) bags and necessary supplies; and
- ➢ Urinary retention catheters, tubes, and bags (does not include irrigation supplies);

✓ Supplies for intermittent catheterization programs (the catheter is inserted and removed each time the procedure is done); and

- ✓ Surgical dressings required as a result of a surgical procedure (does not include decubitus care). Allowed for up to six (6) weeks postsurgery.

- **Compliance Packaging** (Billable by pharmacists ONLY) **(Refer to WAC 388-530-1625)**

Prescribers are encouraged to communicate to high risk clients the need for compliance packaging if, in their professional judgement, such packaging is appropriate.

Clients are considered high risk and eligible to receive compliance devices if they:

- ✓ Are **not** in a nursing facility; **and**
- ✓ Have one or more of the following representative disease conditions: Alzheimer's disease, blood clotting disorders, cardiac arrhythmia, congestive heart failure, depression, diabetes, epilepsy, HIV/AIDS, hypertension, schizophrenia, or TB.

-AND-

- ✓ Consume two or more prescribed chronic medications concurrently which are dosed at three or more intervals per day; **or**
- ✓ Have demonstrated a pattern of noncompliance that is potentially harmful to their health.

- **Disposable Incontinent Products [Refer to WAC 388-543-1150]**

Specifications

- ✓ All adult and children's diapers, incontinent pants, pull-up training pants, underpads, diaper doublers, and liners/shields must meet the following specifications to be covered by MAA:

  - ➢ Padding provides uniform protection.
  - ➢ Product is hypoallergenic.
  - ➢ Adhesives and glues used during construction are not water-soluble and form continuous seals at the edges of the absorbent core to minimize leakage.
  - ➢ All materials used in construction of the product are safe for clients' skin and are harmless if ingested.
  - ➢ Product meets flammability requirements of both federal law and industry standards.

In addition to the specifications on the preceding page, the following specifications must be met for each of the following types of products:

✓ **Adult Briefs/Children's Diapers**

- Hourglass shaped with formed leg contours.
- Absorbent filler core is at least ½ inch from elastic leg gathers.
- Leg gathers consist of at least three strands of elasticized materials.
- Absorbent core consists of cellulose fibers mixed with absorbent gelling materials.
- Backsheet is moisture impervious; at least 1 mm thickness designed to protect clothing and linens.
- Topsheet resists moisture return to skin.
- There are at least four refastenable tapes (two on each side) for briefs; two refastenable tapes (one on each side) for diapers. The tapes should have an adhesive coating that will release from the backsheet without tearing it. The tape adhesive permits a minimum of three fastening/unfastening cycles or has a continuous waistband or side panels with a tear away feature.
- Inner lining is made of soft, absorbent material.

(Briefs and diapers should have a wetness indicator that clearly indicates degree of wetness.)

✓ **Pull-up Training Pants/Incontinent Pants**

- Made like regular underwear with an elastic waist.
- Absorbent filler core is at least ½ inch from elastic leg gathers.
- Leg gathers consist of at least three strands of elasticized materials.
- Absorbent core consists of cellulose fibers mixed with absorbent gelling materials.
- Backsheet is moisture impervious, at least 1 mm thickness, designed to protect clothing and linens.
- Topsheet resists moisture return to skin.
- Inner lining is made of soft, absorbent material.

(Pants should have a wetness indicator that clearly indicates degree of wetness.)

✓ **Underpads**

- Absorbency layer is within 1½ inches from the edge of the underpad.
- Manufactured with a waterproof backing material and withstands temperatures not to exceed 140° F.
- Covering or facing sheet is made with non-woven, porous materials having a high degree of permeability allowing fluids to pass through and into absorbent filler. Patient contact surface is soft and durable. Filler material is highly absorbent: fluff filler, with polymers, heavy weight fluff filler or equivalent.
- Four-ply, non-woven facing, sealed on all four sides.

✓ **Liners/Shields (Including pads and undergarments)**

- Product has channels to direct fluid throughout the absorbent area, and gathers to assist in controlling leakage, and/or is contoured to permit a more comfortable fit.
- Product has a waterproof backing to protect clothing and linens.
- Inner liner resists moisture return to skin.
- Absorbent core consists of cellulose fibers mixed with absorbent gelling materials.
- Undergarments may be belted or unbelted.
- Undergarments are to be contoured for good fit, with three elastic gathers per leg.
- Product has pressure sensitive tapes on reverse side to fasten to underwear.

Limitations:

Any exception to exceed the following limitations requires prior authorization:

✓ The monthly quantity limitation is a maximum allowance. The client is to receive only the amount medically necessary for one month.

✓ Disposable diapers or pants or rental of reusable diapers or pants are not allowed in combination with any other disposable diapers or pants or reuseable diapers or pants with the following exception:

- ✓ Modifier "59," to designate daytime only usage, may be used to allow a combination of diapers, pants, and liners. However, the quantity of the combined products is not to exceed the monthly limitation (300 for children/youth and 240 for adults).

✓ Undergarments are to be billed as liners/pads, not diapers or incontinent pants.

- ✓ Liners/pads will not be allowed in combination with any disposable diapers, pants or rental of reuseable diapers or pants with the following exception:

  - ✓ Modifier "59," to designate daytime only usage, may be used to allow a combination of liners, diapers, and pants. However, the quantity of the combined products is not to exceed the monthly limitation (300 for children/youth and 240 for adults).

- ✓ Underpads are for use on client's bed for incontinence protection only.

- ✓ Diaper doublers require prior authorization. Also see expedited prior authorization criteria on pages E.5 and E.6.

What if a service is covered but considered experimental or has restrictions or limitations? [WAC 388-543-1100 (3) and (4)]

- MAA evaluates a request for a service that is in a covered category, but has been determined to be experimental or investigational as defined by WAC 388-531-0050, under the provisions of WAC 388-501-0165 which relate to medical necessity.

- MAA evaluates a request for a covered service that is subject to limitations or other restrictions and approves such a service beyond those limitations or restrictions when medically necessary, under the standards for covered services in WAC 388-501-0165 (see page E.3 for limitation extensions).

How can I request that equipment/supplies be added to the "covered" list in these billing instructions?

[Refer to WAC 388-543-1100 (7)]

An interested party may request MAA to include new MSE in these billing instructions by sending a written request to MAA's DME Program Management Unit (see *Important Contacts* section). Include all of the following:

- Manufacturer's literature;
- Manufacturer's pricing;
- Clinical research/case studies (including FDA approval, if required); and
- Any additional information the requestor feels is important.

What is not covered? [Refer to WAC 388-543-1300]

MAA specifically excludes services and equipment in this billing instruction from fee-for-service (FFS) scope of coverage when the services and equipment do not meet the definition for a covered item, or the services are not typically medically necessary. This exclusion does not apply if the services and equipment are:

- Required as a result of an EPSDT screening;
- Included as part of a managed care plan service package;
- Included in a waivered program; or
- Part of one of the Medicare programs for Qualified Medicare Beneficiaries.

MAA specifically excludes the following services and equipment from fee-for-service scope of coverage:

- Services, procedures, treatment, devices, drugs, or the application of associated services that the department of the Food and Drug Administration (FDA) and/or the Health Care Financing Administration (HCFA) consider investigative or experimental on the date the services are provided;
- Any service specifically excluded by statute;
- More costly services or equipment when MAA determines that less costly, equally effective services or equipment are available;
- Bilirubin lights, except as rentals, for at-home newborns with jaundice;
- Procedures, prosthetics, or supplies related to gender dysphoria surgery;
- Supplies and equipment used during a physician office visit, such as tongue depressors and surgical gloves;

- Non-medical equipment, supplies, and related services, including but not limited to, the following:

  - ✓ Cleaning brushes and supplies, except for ostomy-related cleaners/supplies;
  - ✓ Identification bracelets;
  - ✓ Instructional materials, such as pamphlets and videotapes;
  - ✓ Recreational equipment;
  - ✓ Room fresheners/deodorizers;
  - ✓ Sitz bath, bidet or hygiene systems, paraffin bath units, and shampoo rings;
  - ✓ Timers or electronic devices to turn things on or off;
  - ✓ Carpet cleaners/deodorizers, and/or pesticides/insecticides; or

- Personal and comfort items including, but not limited to, the following:

  - ✓ Bathroom items, such as antiperspirant, astringent, bath gel, conditioner, deodorant, moisturizers, mouthwash, powder, sanitary napkins (e.g., Kotex), shampoo, shaving cream, shower cap, shower curtains, soap, toothpaste, towels, and weight scales;
  - ✓ Bedding items, such as bed pads, blankets, mattress covers/bags, pillows, and sheets;
  - ✓ Bedside items, such as bed trays, carafes, and over-the-bed tables;
  - ✓ Clothing and accessories, such as coats, gloves (including wheelchair gloves), hats, scarves, slippers, and socks;
  - ✓ Clothing protectors and other protective cloth furniture coverings as protection against incontinence;
  - ✓ Cosmetics, including corrective formulations, hair depilatories, and products for skin bleaching, sun screens, and tanning;
  - ✓ Diverter valves for bathtub;
  - ✓ Eating/feeding utensils;
  - ✓ Emesis basins, enema bags, and diaper wipes;
  - ✓ Hot or cold temperature food and drink containers/holders;
  - ✓ Hot water bottles and cold/hot packs or pads;
  - ✓ Insect repellants;
  - ✓ Massage equipment;
  - ✓ Medication dispensers, such as med-collators and count-a-dose, except as obtained under the compliance packaging program. See chapter 388-530 WAC;
  - ✓ Medicine cabinet and first aid items, such as adhesive bandages (e.g., Band-Aids, Curads), cotton balls, cotton-tipped swabs, medicine cups, thermometers, and tongue depressors;
  - ✓ Page turners;
  - ✓ Telephones, telephone arms, cellular phones, electronic beepers, and other telephone messaging services; and
  - ✓ Toothettes and toothbrushes, waterpics, and peridontal devices whether manual, battery-operated, or electric.

Authorization

What is prior authorization?

Prior authorization (PA) is MAA's approval for certain medical services, equipment, or supplies, before the services are provided to clients, as a precondition for provider reimbursement. **Expedited prior authorization (EPA) and limitation extensions are forms of prior authorization.**

Which items and services require prior authorization?

[Refer to WAC 388-543-1600 and 2800]

MAA bases its determination about which MSE and related services require PA or EPA on utilization criteria. MAA considers all of the following when establishing utilization criteria:

- High cost;
- Potential for utilization abuse;
- Narrow therapeutic indication; and
- Safety.

MAA requires providers to obtain PA for the following:

- Certain By Report (BR) MSE as specified in these billing instructions;
- Blood glucose monitors requiring special features;
- Decubitus care products and supplies;
- Other MSE not specifically listed in these billing instructions and submitted as a miscellaneous procedure code; and
- Limitation extensions.

MAA requires providers to obtain PA for items and services when the client fails to meet the expedited prior authorization criteria in these billing instructions.

General Policies for Prior Authorization

[Refer to WAC 388-543-1800]

- For PA requests, MAA requires the prescribing provider to furnish patient-specific justification for base equipment and each requested line item accessory or modification as identified by the manufacturer as a separate charge. MAA does not accept general standards of care or industry standards for generalized equipment as justification.

- When MAA receives an initial request for PA, the prescription(s) for those items or services cannot be older than three months from the date MAA receives the request.

- MAA requires certain information from providers in order to prior authorize the purchase or rental of equipment. This information includes, but is not limited to, the following:

  - ✓ The manufacturer's name;
  - ✓ The equipment model and serial number;
  - ✓ A detailed description of the item; and
  - ✓ Any modifications required, including the product or accessory number as shown in the manufacturer's catalog.

- MAA authorizes BR items that require PA and are listed in the *Fee Schedule* only if medical necessity is established and the provider furnishes all of the following information to MAA:

  - ✓ A detailed description of the item or service to be provided;
  - ✓ The cost or charge for the item;
  - ✓ A copy of the manufacturer's invoice, price list or catalog with the product description for the item being provided; and
  - ✓ A detailed explanation of how the requested item differs from an already existing code description.

- A provider may resubmit a request for PA for an item or service that MAA has denied. MAA requires the provider to include new documentation that is relevant to the request.

- If a provider does not obtain prior authorization, MAA will deny the billing, and the client must not be held financially responsible for the service.

☞ **Note:** Written requests for prior authorization must be submitted to MAA on a HCFA-1500 claim form with the date of service left blank and a copy of the prescription attached.

What is a limitation extension? [Refer to WAC 388-543-2800 (3)]

A limitation extension is when MAA allows additional units of service for a client when the provider can verify that the additional units of service are medically necessary. Limitation extensions require authorization. Please see the *Fee Schedule* for a complete list of limitations. [Refer to WAC 388-543-1150]

☞ **Note:** Requests for limitation extensions must be appropriate to the client's eligibility and/or program limitations. Not all eligibility groups cover all services.

How do I request a limitation extension?

In cases where the provider feels that additional services are still medically necessary for the client, the provider must request MAA-approval in writing.

The request must state the following in writing:

1. The name and PIC number of the client;
2. The provider's name, provider number and fax number;
3. Additional service(s) requested;
4. Copy of last prescription and date dispensed;
5. The primary diagnosis code and HCPCS code; and
6. Client-specific clinical justification for additional services.

Send your written request for a limitation extension to:

Write/Call:
Division of Medical Management
Durable Medical Equipment
PO Box 45506
Olympia, WA 98504-5506
(360) 586-5299 Fax

What is expedited prior authorization?

The expedited prior authorization process (EPA) is designed to eliminate the need for written and telephonic requests for prior authorization for selected MSE procedure codes. MAA allows payment during a continuous 12-month period for this process.

To bill MAA for MSE that meet the EPA criteria on the following pages, the vendor must create a 9-digit EPA number. The first 6 digits of the EPA number must be **870000.** The last 3 digits must be the code number of the product and documented medical condition that meets the EPA criteria. Enter the EPA number on the HCFA-1500 claim form in the ***Authorization Number*** field or in the ***Authorization*** or ***Comments*** field when billing electronically. With HIPAA implementation, multiple authorization (prior/expedited) numbers can be billed on a claim. If you are billing **multiple** EPA numbers, you must list the 9-digit EPA numbers in field 19 of the claim form **exactly** as follows (*not all required fields are represented in the example*):

19. Line 1: 870000725/ Line 2: 870000726

If you are only billing one EPA or PA number on a paper HCFA-1500 claim form, please continue to list the 9-digit EPA number in field 23 of the claim form.

Example: The 9-digit EPA number for a breast pump kit for a client that meets all of the EPA criteria would be **870000764** (870000 = first 6 digits, 764 = product and documented medical condition).

Vendors are reminded that EPA numbers are only for those products listed on the following pages. EPA numbers are not valid for:

- Other MSE requiring prior authorization through the Durable Medical Equipment program;
- Products for which the documented medical condition does not meet all of the specified criteria; or
- Over-limitation requests.

The written or telephonic request for prior authorization process must be used when a situation does not meet the criteria for a selected MSE code. Providers must submit the request to the DME Program Management Unit or call the authorization toll-free number at 1-800-292-8064. (See *Important Contacts* section.) [WAC 388-543-1900 (3)]

Expedited Prior Authorization Guidelines:

A. **Medical Justification (criteria)** - All medical justification must come from the client's prescribing physician or physical/occupational/speech therapist with an appropriately completed prescription. MAA does not accept information obtained from the client or from someone on behalf of the client (e.g. family).

B. **Documentation** - The billing provider **must keep** documentation of the criteria in the client's file. Upon request, a provider must provide documentation to MAA showing how the client's condition met the criteria for EPA. Keep documentation file for six (6) years. [Refer to WAC 388-543-1900 (4)]

☞ **Note:** MAA may recoup any payment made to a provider under this section if the provider did not follow the expedited authorization process and criteria. Refer to WAC 388-502-0100. [WAC 388-543-1900 (5)]

Washington State
Expedited Prior Authorization Criteria Coding List

Code	Criteria	Code	Criteria

☞**Note: The following pertains to EPA numbers 764 - 863:**

1) If the medical condition does not meet **all** of the specified criteria, prior authorization must be obtained by submitting a request in writing to DME Program Management Unit (see the *Important Contacts* section) or by calling the authorization toll-free number at 1-800-292-8064.
2) It is the vendor's responsibility to determine whether the client has already used the product allowed with the EPA criteria within the previous 30 days.
3) For extension of authorization beyond the EPA amount allowed, the normal prior authorization process is required.
4) Must have a valid physician prescription as described in WAC 388-543-1100(d))
5) Length of need/life expectancy, as determined by the prescribing physician, and medical justification (including **all** of the specified criteria) must be documented in the client's file.
6) You may bill for only one procedure code, per client, per month.

Miscellaneous Supplies
Procedure Code: E1399

764 Breast pump kit for electric breast pump. Purchase allowed when all of the following criteria are met:

a) When needed for use with an authorized electric breast pump (either prior authorization or EPA);

b) Client is not in a nursing facility; and

c) When prescribed by a physician.

Procedure Code: A4335

851 Incontinence supply, use for diaper doublers, each (age 3 and up). Included in nursing facility daily rate. Purchase of 90 per month allowed when all of the following criteria are met:

a) If product is used for extra absorbency at nighttime only; and

b) When prescribed by a physician.

852 Incontinence supply, use for diaper doublers, each (age 3 and up). Included in nursing facility daily rate. Up to equal amount of diapers/briefs received if one of the following criteria for clients is met:

a) Tube fed;

b) On diuretics or other medication that causes frequent/large amounts of output; or

c) Brittle diabetic with blood sugar problems.

Procedure Code: E1399

853 Disinfectant spray, 12 oz. Purchase of 1 per client every 6 months when all of the following criteria are met:

a) Client is not in a nursing facility; and
b) When prescribed by a physician.

Procedure Code: E1399

861 Lice comb, such as LiceOut™, LeisMeister™, or combs of equivalent quality and effectiveness. Will allow 1 per client, per year when all of the following criteria are met:

a) Client is not in a nursing facility; and
b) When prescribed by a physician.

Code	Criteria	Code	Criteria

Procedure Code: E1399

862 Non-toxic gel such as LiceOut™ for use with lice combs, per 8 oz bottle. Allow 1 bottle per client, per year when all of the following criteria are met:

a) For use with a medically justified LiceComb™;

b) Client is not in a nursing facility; and

c) When prescribed by a physician.

Procedure Code: E1399

863 "Sharps" disposal container for home use, up to one gallon size, each. Purchase of 2 per month allowed when all of the following criteria are met:

a) Client is not in a nursing facility; and
b) When prescribed by a physician.

☞ **Note:** The following criteria pertains to the four procedure codes listed below. Clients will be considered high-risk and eligible to receive compliance devices if they:

- Do not reside in a skilled nursing facility or other inpatient facility; and
- Have one or more of the following representative disease conditions: Alzheimer's disease, blood clotting disorders, cardiac arrhythmia, congestive heart failure, depression, diabetes, epilepsy, HIV/AIDS, hypertension, schizophrenia, or tuberculosis;

- AND -

- Concurrently consume two or more prescribed medications for chronic medical conditions that are dosed at three or more intervals per day; or
- Have demonstrated a pattern of noncompliance that is potentially harmful to the client's health. The client's pattern of noncompliance with the prescribed drug regimen must be fully documented in the provider's file.

For questions related to compliance packaging, call the Pharmacy Prior Authorization Section, Drug Utilization and Review at: (800) 848-2842.

Prefilling a syringe is not considered compliance packaging.

Compliance Packaging
Procedure Code: T1999

864 Reusable compliance device/container (e.g., medisets, weekly minders, etc.). Limit of four devices/containers per client, per year when criteria in above shaded box is met.

Procedure Code: T1999

865 Nonreusable compliance device/container (e.g., blister packs, bingo cards, bubble packs, etc.). Limit of four devices/ containers per client, per year when criteria in above shaded box is met.

Compliance Packaging (cont.)
Procedure Code: T1999

866 Reusable compliance device or container, extra large capacity. Limit of four per client, per year.

Procedure Code: A9901

867 Filling fee for reusable compliance device or container. Limit of four fills per client, per month.

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Reimbursement

Reimbursement for MSE and Related Services

[Refer to WAC 388-543-1400 (1) (3) (5) and WAC 388-543-2900 (3) (4)]

- MAA reimburses a qualified provider who serves fee-for-service (FFS) clients only when all of the following apply:

  - ✓ The provider meets all of the conditions in WAC 388-502-0100; and

  - ✓ MAA does not include the item/service for which the provider is requesting reimbursement in other reimbursements. Other reimbursements include, but are not limited to, the following:

    - ➢ Hospice providers' per diem reimbursement;
    - ➢ Hospital's diagnosis related group (DRG) reimbursement;
    - ➢ Managed care plans' capitation rate; and
    - ➢ Nursing facilities' per diem rate.

- MAA's nursing facility per diem rate includes any reusable and disposable medical supplies that may be required for a nursing facility client. MAA may reimburse the following medical supplies separately for a client in a nursing facility:

  - ✓ Medical supplies or services that replace all or parts of the function of a permanently impaired or malfunctioning internal body organ. This includes, but is not limited, to the following:

    - ➢ Colostomy and other ostomy bags and necessary supplies; and
    - ➢ Urinary retention catheters, tubes, and bags, excluding irrigation supplies;

  - ✓ Supplies for intermittent catheterization programs, for the following purposes:

    - ➢ Long term treatment of atonic bladder with a large capacity; and
    - ➢ Short term management for temporary bladder atony; and
    - ➢ Surgical dressings required as a result of a surgical procedure, for up to six weeks after surgery.

- MAA considers decubitus care products to be included in the nursing facility per diem rate and does not reimburse for these separately.

- MAA may adopt policies, procedure codes, and/or rates that are inconsistent with those set by Medicare if MAA determines that such actions are in the best interest of its clients.

- A provider must not bill MAA for the purchase of equipment supplied to the provider at no cost by suppliers/manufacturers.

When does MAA not reimburse under fee-for-service?
[WAC 388-543-1100 (5)]

MAA does not reimburse for MSE and labor charges under FFS when the client is any of the following:

- An inpatient hospital client;
- Eligible for both Medicare and Medicaid, and is staying in a nursing facility in lieu of hospitalization;
- Terminally ill and receiving hospice care; or
- Enrolled in a risk-based managed care plan that includes coverage for such items and/or services.

Fee Schedule

A Few Notes about the Fee Schedule

Procedure Code Description

The description of each code will tell you when:

- Prior authorization is required;
- Expedited prior authorization criteria is available;
- There are specific limitations;
- Codes are not allowed in combination with primary code;
- An item is taxable;
- An item is included in the nursing facility daily rate; and
- One of the following modifiers is required:

✓	KX –	Insulin Dependent;
✓	KS –	Non-Insulin Dependent;
✓	RP –	Replacement;
✓	RR –	Rental;
✓	NU –	Purchase;
✓	A1-A9 –	See "Dressings," pg. G.5; or
✓	59	See "Disposable Incontinent Products" page D.3 and "Urological Supplies" page G.22.

Maximum Allowance

The maximum dollar amount payable by MAA is indicated in the *Maximum Allowable* column.

Non-Durable Medical Supplies and Equipment (MSE)
HCPCS, Modifiers, Descriptions, Rates

HCPCS	October 1, 2003 Maximum Allowable	Modifier	Description
			***Billing provision limited to one (1) month's supply*** .
			COMPLIANCE PACKAGING **(Billable only by pharmacists for non-institutionalized at-risk clients.)**
A9901	$2.50		Delivery/set up/dispensing. Included in nursing facility daily rate. **Limit of four fills per client, per month.** ***Replaces code 4801A. EPA #870000867 must be used when billing this item.***
T1999	$6.00		Reusable compliance device/container (e.g., medisets, weekly minders, etc.) Included in nursing facility daily rate. **Limit of four devices/containers per client, per year.** ***Replaces code 4800A. EPA #870000864 must be used when billing this item.***
T1999	$3.00		Nonreusable compliance device/container (e.g., blister packs, bingo cards, bubble packs, etc.) Included in nursing facility daily rate. **Limit of four devices/containers per month, per client.** ***Replaces code 4802A. EPA #870000865 must be used when billing this item.***
T1999	$16.91		Reusable compliance device/container, extra large capacity (e.g., medisets, weekly minders, etc.). Included in nursing facility rate. **Limit of four devices/containers per year, per client.** ***Replaces code 4804A. EPA #870000866 must be used when billing this item.***
			****Note: Providers may bill compliance devices/containers in any combination, but not to exceed a total of 4 per year.***
			EMERGENCY CONTRACEPTION PILLS (ECP) COUNSELING **(Billable only by pharmacists who meet Board of Pharmacy protocols.)**
			***Billing provision limited to one (1) month's supply*** .
S9445	$13.50		Patient education, not otherwise classified, non-physician provider, individual, per session. ***Replaces code 4805A.***

HCPCS	October 1, 2003 Maximum Allowable	Modifier	Description
			Billing provision limited to one (1) month's supply .
			SYRINGES AND NEEDLES
			Billing provision limited to one (1) month's supply .
A4206	65%		Syringe with needle, sterile 1cc, each. Included in nursing facility daily rate. ***Replaces code 4803A.***
A4207	65%		Syringe with needle, sterile 2cc, each. Included in nursing facility daily rate. ***Replaces code 4803A.***
A4208	65%		Syringe with needle, sterile 3cc, each. Included in nursing facility daily rate. ***Replaces code 4803A.***
A4209	65%		Syringe with needle, sterile 5cc or greater, each. Included in nursing facility daily rate. ***Replaces code 4803A.***
A4210	65%		Needle free injection device, each. ***Replaces code 4803A.***
A4215	65%		Needles only, sterile, any size, each. Included in nursing facility daily rate.
A4322	$3.04		Irrigation syringe, bulb or piston, each. Included in nursing facility daily rate. **Not allowed in combination with code A4320, A4355.**
			BLOOD MONITORING/TESTING SUPPLIES
			Billing provision limited to one (1) month's supply .
A4253	$34.80		Blood glucose test or reagent strips for home blood glucose monitor, per 50 strips. Included in nursing facility daily rate. **Modifier KX or KS required.**
A4254	$6.58		Replacement battery, any type, for use with medically necessary home blood glucose monitor owned by patient, each. **One (1) allowed per client every 3 months.**
A4256	$11.44		Normal, low and high calibrator solution/chips. Included in nursing facility daily rate.

HCPCS	October 1, 2003 Maximum Allowable	Modifier	Description
			Billing provision limited to one (1) month's supply .
A4258	$18.05		Spring-powered device for lancet, each. **One (1) allowed per client every 6 months**. Included in nursing facility daily rate.
A4259	$12.74		Lancets, per box of 100. Included in nursing facility daily rate. **Modifier KX or KS required.**
PREGNANCY-RELATED TESTING KITS AND NURSING EQUIPMENT SUPPLIES			
			Billing provision limited to one (1) month's supply .
E1399	$7.34		Durable Medial Equipment Miscellaneous. (Pregnancy testing kit, 1 test per kit. **Not allowed for clients enrolled in the Family Planning Only or TAKE CHARGE programs.** ***Prior authorization required. Replaces code 0178A.)***
E1399	$37.92		Durable Medial Equipment Miscellaneous. (Breast pump kit for electric breast pump. **Purchase only.** ***Replaces code 0181A. EPA# 870000764 must be used when billing this code.)***
ANTISEPTICS AND GERMICIDES			
			Billing provision limited to one (1) month's supply .
A4244	$0.76		Alcohol or peroxide, per pint. Included in nursing facility daily rate. **Maximum of one (1) pint allowed per client per 6 months.**
A4245	$2.30		Alcohol wipes, per box (of 200). Included in nursing facility daily rate. **Maximum of one (1) box allowed per client per month.**
A4246	$3.03		Betadine or pHisoHex solution, per pint. Included in nursing facility daily rate. **Maximum of one (1) pint allowed per client per month.**
A4247	$4.72		Betadine or iodine swabs/wipes, per box (of 100). Included in nursing facility daily rate. **Maximum of one (1) box allowed per client per month.**
E1399	$5.21		Durable Medial Equipment Miscellaneous. (Disinfectant spray, 12 oz. Included in nursing facility daily rate. **Maximum of one (1) allowed per client per 6 months.** ***Replaces code 0157A. EPA# 870000853 must be used when billing this code.)***

HCPCS	October 1, 2003 Maximum Allowable	Modifier	Description
			Billing provision limited to one (1) month's supply .
			BANDAGES, DRESSINGS, AND TAPES **Unless needed for first 6 weeks postsurgery, all bandages dressing/tapes are included in the nursing facility daily rate**
			Billing provision limited to one (1) month's supply .
A4649	65%		Surgical supply, miscellaneous. ***Prior Authorization required.***
A6021	$21.02		Collagen dressing, pad size 16 sq. in. or less, each
A6022	$21.02		Collagen dressing, pad size more than 16 sq. in. but less than or equal to 48 sq. in., each
A6023	$190.30		Collagen dressing, pad size more than 48 sq. in. ***Prior Authorization required.***
A6024	$6.19		Collagen dressing wound filler, per 6 inches
A6154	$14.36		Wound pouch, each.
A6196	$7.35		Alginate or other fiber gelling dressing, wound cover, pad size 16 sq. in. or less, each dressing.
A6197	$16.44		Alginate or other fiber gelling dressing, wound cover, pad size more than 16 sq. in., but less than or equal to 48 sq. in., each dressing.
A6198	65%		Alginate or other fiber gelling dressing, wound cover, pad size more than 48 sq. in, each dressing.
A6199	$5.29		Alginate or other fiber gelling dressing, wound filler, per 6 inches.
A6200	$9.50		Composite dressing, pad size 16 sq. in. or less, without adhesive border, each dressing.
A6201	$20.80		Composite dressing, pad size more than 16 sq. in., but less than or equal to 48 sq. in., without adhesive border, each dressing.

HCPCS	October 1, 2003 Maximum Allowable	Modifier	Description
			Billing provision limited to one (1) month's supply .
A6202	$34.88		Composite dressing, pad size more than 48 sq. in., without adhesive border, each dressing.
A6203	$3.35		Composite dressing, pad size 16 sq. in. or less, with any size adhesive border, each dressing.
A6204	$6.23		Composite dressing, pad size more than 16 sq. in., but less than or equal to 48 sq. in. with any size adhesive border, each dressing.
A6205	65%		Composite dressing, pad size more than 48 sq. in. with any size adhesive border, each dressing.
A6206	$5.29		Contact layer, 16 sq. in. or less, each dressing.
A6207	$7.34		Contact layer, more than 16 sq. in., but less than or equal to 48 sq. in., each dressing.
A6208	65%		Contact layer, more than 48 sq. in., each dressing.
A6209	$7.48		Foam dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing.
A6210	$19.92		Foam dressing, wound cover, pad size more than 16 sq. in., but less than or equal to 48 sq. in., without adhesive border, each dressing.
A6211	$29.37		Foam dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing.
A6212	$9.70		Foam dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing.
A6213	$20.00		Foam dressing, wound cover, pad size more than 16 sq. in., but less than or equal to 48 sq. in., with any size adhesive border, each dressing.
A6214	$10.29		Foam dressing, wound cover, pad size more than 48 sq. in., with any size adhesive border, each dressing.
A6215	$2.99		Foam dressing, wound filler, per gram.

HCPCS	October 1, 2003 Maximum Allowable	Modifier	Description
			Billing provision limited to one (1) month's supply .
A6216	$0.05		Gauze, non-impregnated, non-sterile, pad size 16 sq. in. or less, without adhesive border, each dressing.
A6217	$0.17		Gauze, non-impregnated, non-sterile, pad size more than 16 sq. in. but less than or equal to 48 sq. in. without adhesive border, each dressing.
A6218	$0.45		Gauze, non-impregnated, non-sterile pad size more than 48 sq. in., without adhesive border, each dressing.
A6219	$0.95		Gauze, non-impregnated, pad size 16 sq. in. or less, with any size adhesive border, each dressing.
A6220	$2.58		Gauze, non-impregnated, pad size more than 16 sq. in., but less than or equal to 48 sq. in., with any size adhesive border, each dressing.
A6221	65%		Gauze, non-impregnated, pad size more than 48 sq. in., with any size adhesive border, each dressing.
A6222	$2.13		Gauze, impregnated with other than water, normal saline or hydrogel, pad size 16 sq. in. or less, without adhesive border, each dressing.
A6223	$2.42		Gauze, impregnated with other than water, normal saline or hydrogel, pad size more than 16 sq. in., but less than or equal to 48 sq. in., without adhesive border, each dressing.
A6224	$3.61		Gauze, impregnated with other than water, normal saline or hydrogel, pad size more than 48 sq. in., without adhesive border, each dressing.
A6228	$0.99		Gauze, impregnated, water or normal saline, pad size 16 sq. in. or less, without adhesive border, each dressing.
A6229	$3.61		Gauze, impregnated, water or normal saline, pad size more than 16 sq. in., but less than or equal to 48 sq. in., without adhesive border, each dressing.
A6230	65%		Gauze, impregnated, water or normal saline, pad size more than 48 sq. in., without adhesive border, each dressing.

HCPCS	October 1, 2003 Maximum Allowable	Modifier	Description
☞	***Billing provision limited to one (1) month's supply*** .		
A6234	$6.54		Hydrocolloid dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing.
A6235	$16.82		Hydrocolloid dressing, wound cover, pad size more than 16 sq. in., but less than or equal to 48 sq. in., without adhesive border, each dressing.
A6236	$27.25		Hydrocolloid dressing, wound cover, pad size more than 48 sq., without adhesive border, each dressing.
A6237	$7.91		Hydrocolloid dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing.
A6238	$22.79		Hydrocolloid dressing, wound cover, pad size more than 16 sq. in., but less than or equal to 48 sq. in., with any size adhesive border, each dressing.
A6239	65%		Hydrocolloid dressing, wound cover, pad size more than 48 sq. in., with any size adhesive border, each dressing.
A6240	$12.24		Hydrocolloid dressing, wound filler, paste, per fluid oz.
A6241	$2.57		Hydrocolloid dressing, wound filler, dry form, per gram.
A6242	$6.07		Hydrogel dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing.
A6243	$12.31		Hydrogel dressing, wound cover, pad size more than 16 sq. in., but less than or equal to 48 sq. in., without adhesive border, each dressing.
A6244	$39.28		Hydrogel dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing.
A6245	$7.27		Hydrogel dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing.
A6246	$9.92		Hydrogel dressing, wound cover, pad size more than 16 sq. in., but less than or equal to 48 sq. in., with any size adhesive border, each dressing.

HCPCS	October 1, 2003 Maximum Allowable	Modifier	Description
			Billing provision limited to one (1) month's supply .
A6247	$23.78		Hydrogel dressing, wound cover, pad size more than 48 sq. in., with any size adhesive border, each dressing.
A6248	$16.24		Hydrogel dressing, wound filler, gel, per fluid oz.
A6251	$1.99		Specialty absorptive dressing, wound cover, pad size 16 sq. in. or less, without adhesive border, each dressing.
A6252	$3.25		Specialty absorptive dressing, wound cover, pad size more than 16 sq. in., but less than or equal to 48 sq. in, without adhesive border, each dressing.
A6253	$6.34		Specialty absorptive dressing, wound cover, pad size more than 48 sq. in., without adhesive border, each dressing.
A6254	$1.21		Specialty absorptive dressing, wound cover, pad size 16 sq. in. or less, with any size adhesive border, each dressing.
A6255	$3.03		Specialty absorptive dressing, wound cover, pad size more than 16 sq. in., but less than or equal to 48 sq. in., with any size adhesive border, each dressing.
A6256	65%		Specialty absorptive dressing, wound cover, pad size more than 48 sq. in., with any size adhesive border, each dressing.
A6257	$1.53		Transparent film, 16 sq. in. or less, each dressing.
A6258	$4.30		Transparent film, more than 16 sq. in., but less than or equal to 48 sq. in., each dressing.
A6259	$10.94		Transparent film, more than 48 sq. in., each dressing.
A6260	$1.11		Wound cleaners, any type, any size (per ounce).
A6261	65%		Wound filler, gel/paste, per fluid ounce, not elsewhere classified. ***Prior authorization required.***
A6262	65%		Wound filler, dry form, per gram, not elsewhere classified. ***Prior authorization required.***

HCPCS	October 1, 2003 Maximum Allowable	Modifier	Description
			Billing provision limited to one (1) month's supply .
A6263	N/A		***Discontinued for dates of service on and after October 1, 2003.***
A6264	N/A		***Discontinued for dates of service on and after October 1, 2003.***
A6402	$0.12		Gauze, non-impregnated, sterile, pad size 16 sq. in. or less, without adhesive border, each dressing.
A6403	$0.43		Gauze, non-impregnated, sterile, pad size more than 16 sq. in., but less than or equal to 48 sq. in., without adhesive border, each dressing.
A6404	$0.88		Gauze, non-impregnated, sterile, pad size more than 48 sq. in., without adhesive border, each dressing.
A6405	N/A		***Discontinued for dates of service on and after October 1, 2003.***
A6406	N/A		***Discontinued for dates of service on and after October 1, 2003.***
E1399	65%		Durable Medial Equipment Miscellaneous. (Dressing, other. ***Prior Authorization Required. Replaces code 0100A).***
S8431	65%		Compression bandage, roll. *R* ***eplaces codes 4461A, 4462A,4463A, 4464A and 4465A.***
K0620	65%		Tubular elastic dressing, any width, per linear yard. ***Replaces codes 4466A, 4467A, 4468A, 4469A, 4470A, 4471A, 4472A, 4473A, 4474A, 4475A, 4476A, 4477A, 4478A, 4479A, 4480A, 4481A, and 4482A.***

TAPES

Unless needed for first 6 weeks postsurgery, all bandages dressing/tapes are included in the nursing facility daily rate

			Billing provision limited to one (1) month's supply .
A4462	$3.29		Abdominal dressing holder/binder, each.
A4450	$0.09		Non-waterproof tape, per 18 square inches. (1 unit = 18 square inches) Example: 2 inch wide tape by 36 yards. 2 inches x 1 yard = 72 inches time 36 yards is 2,592 divided by 18 is 144 units. ***Replaces codes 0094A, 0095A, 0098A, 4585A, 4595A, 4767A, 4768A, 4769A and 4771A.***

HCPCS	October 1, 2003 Maximum Allowable	Modifier	Description
			Billing provision limited to one (1) month's supply .
A4452	$0.36		Waterproof tape, per 18 square inches. (1 unit = 18 square inches) Example: 2 inch wide tape by 36 yards. 2 inches x 1 yard = 72 inches time 36 yards is 2,592 divided by 18 is 144 units. ***Replaces codes 0090A, 4760A, 4761A, 4762A, 4763A, 4764A, 4765A, 4766A and 4799A.***
OSTOMY SUPPLIES (NOTE: ITEMS IN THIS CATEGORY ARE NOT TAXABLE)			
			Billing provision limited to one (1) month's supply .
A4361	$18.37		Ostomy faceplate, each. **Maximum of 10 allowed per client per month. Not allowed in combination with codes A4375, A4376, A4379, A4380.**
A4362	$3.46		Skin barrier, solid, four by four or equivalent, each (for ostomy only).
A4364	$2.73		Adhesive (for ostomy or catheter); liquid, or equal, any type, per oz. **Maximum of 4 allowed per client per month.**
A4365	$11.32		Adhesive remover wipes, any type, per 50. **Maximum of one (1) box allowed per client per month.**
A4367	$6.82		Ostomy belt , each (for appliance; adjustable). **Maximum of two (2) allowed per client every six months.**
A4368	$0.26		Ostomy filter, any type, each.
A4369	$2.06		Ostomy skin barrier, liquid (spray, brush, etc.), per oz.
A4370	N/A		***Discontinued for dates of service on and after October 1, 2003 and replaced by A4405 and A4406.***
A4371	$3.60		Ostomy skin barrier, powder, per oz.
A4372	$4.18		Ostomy skin barrier, solid 4 x 4 or equivalent, with built-in convexity, each.
A4373	$6.28		Ostomy skin barrier, with flange (solid, flexible, or accordion), with built-in convexity, any size, each. ***Replaces code A4374.***

HCPCS	October 1, 2003 Maximum Allowable	Modifier	Description
			Billing provision limited to one (1) month's supply .
A4374	N/A		***Discontinued for dates of service on and after October 1, 2003 and replaced by A4373.***
A4375	$17.18		Ostomy pouch, drainable, with faceplate attached, rubber, each. **Maximum of 10 allowed per client per month. Not allowed in combination with code A4361 or A4377.**
A4376	$47.58		Ostomy pouch, drainable, with faceplate attached, rubber, each. **Maximum of 10 allowed per client per month. Not allowed in combination with code A4361 or A4378.**
A4377	$4.29		Ostomy pouch, drainable, for use on faceplate, plastic, each. **Maximum of 10 allowed per client per month.**
A4378	$30.75		Ostomy pouch, drainable, for use on faceplate, rubber, each. **Maximum of 10 allowed per client per month.**
A4379	$15.02		Ostomy pouch, urinary, with faceplate attached, plastic, each. **Maximum of 10 allowed per client per month. Not allowed in combination with code A4361, A4381 or A4382.**
A4380	$37.33		Ostomy pouch, urinary, with faceplate attached, rubber, each. **Maximum of 10 allowed per client per month. Not allowed in combination with code A4361 or A4383.**
A4381	$4.61		Ostomy pouch, urinary, for use on faceplate, plastic, each. **Maximum of 10 allowed per client per month.**
A4382	$24.62		Ostomy pouch, urinary, for use on faceplate, heavy plastic, each. **Maximum of 10 allowed per client per month.**
A4383	$28.19		Ostomy pouch, urinary, for use on faceplate, rubber, each. **Maximum of 10 allowed per client per month.**
A4385	$5.10		Ostomy skin barrier, solid 4x4 or equivalent, extended wear, without built-in convexity, each.

HCPCS	October 1, 2003 Maximum Allowable	Modifier	Description
			Billing provision limited to one (1) month's supply .
A4386	N/A		***Discontinued for dates of service on and after October 1, 2003 and replaced by A4409.***
A4387	$3.97		Ostomy pouch, closed, with barrier attached, with built-in convexity (1 piece), each. **Maximum of 30 allowed per client per month.**
A4388	$4.36		Ostomy pouch, drainable, with extended wear barrier attached, (1 piece), each. **Maximum of 10 allowed per client per month.**
A4389	$6.22		Ostomy pouch, drainable, with barrier attached, with built-in convexity (1 piece), each. **Maximum of 10 allowed per client per month.**
A4390	$9.61		Ostomy pouch, drainable, with extended wear barrier attached, with built-in convexity (1 piece), each. **Maximum of 10 allowed per client per month.**
A4391	$7.07		Ostomy pouch, urinary, with extended wear barrier attached, (1 piece), each. **Maximum of 10 allowed per client per month.**
A4392	$8.18		Ostomy pouch, urinary, with standard wear barrier attached, with built-in convexity (1 piece), each. **Maximum of 10 allowed per client per month.**
A4393	$9.04		Ostomy pouch, urinary, with extended wear barrier attached, with built-in convexity (1 piece), each. **Maximum of 10 allowed per client per month.**
A4397	$4.79		Irrigation supply; sleeve, each. **Maximum of one (1) allowed per client per month.**
A4398	$13.81		Ostomy irrigation supply; bag, each. **Maximum of two (2) allowed per client every 6 months.**
A4399	$11.55		Ostomy irrigation supply; cone/catheter, including brush. **Maximum of two (2) allowed per client every 6 months.**
A4404	$1.69		Ostomy ring, each. **Maximum of 10 allowed per client per month.**

HCPCS	October 1, 2003 Maximum Allowable	Modifier	Description
			Billing provision limited to one (1) month's supply .
A4405	65%		Ostomy skin barrier, non-pectin based, paste, per ounce. **Replaced A4370.**
A4406	65%		Ostomy skin barrier, pectin based, paste, per ounce. **Replaced A4370.**
A4409	65%		Ostomy skin barrier with flange (Solid flexible or accordion), extended wear, without built-in convexity, 4x4 inches or smaller, each.
A4421	65%		Ostomy supply; miscellaneous. **Prior Authorization required.**
A4455	$1.43		Adhesive remover or solvent (for tape, cement, or other adhesive), per oz. **Maximum of 3 allowed per client per month.**
A5051	$2.07		Ostomy pouch, closed; with barrier attached (one piece) each. **Maximum of 60 allowed per client per month.**
A5052	$2.22		Ostomy pouch, closed; without barrier attached (one piece) each. **Maximum of 60 allowed per client per month.**
A5053	$1.74		Ostomy pouch, closed; for use on faceplate each. **Maximum of 60 allowed per client per month.**
A5054	$1.79		Ostomy pouch, closed; for use on barrier with flange (two piece) each. **Maximum of 60 allowed per client per month.**
A5055	$1.44		Stoma cap. **Maximum of 30 allowed per client per month.**
A5061	$3.53		Ostomy pouch, drainable; with barrier attached (one piece) each. **Maximum of 20 allowed per client per month.**
A5062	$2.09		Ostomy pouch, drainable; without barrier attached (one piece) each. **Maximum of 20 allowed per client per month.**
A5063	$2.17		Ostomy pouch, drainable; for use on barrier with flange (two piece system) each. **Maximum of 20 allowed per client per month.**

HCPCS	October 1, 2003 Maximum Allowable	Modifier	Description
			Billing provision limited to one (1) month's supply .
A5071	$6.01		Ostomy pouch, urinary, with barrier attached (one piece) each. **Maximum of 20 allowed per client per month.**
A5072	$3.52		Ostomy pouch, urinary, without barrier attached (one piece) each. **Maximum of 20 allowed per client per month.**
A5073	$3.13		Ostomy pouch, urinary, for use on barrier with flange (two piece) each. **Maximum of 20 allowed per client per month.**
A5081	$2.81		Continent device; plug for continent stoma. **Maximum of 30 allowed per client per month.**
A5082	$10.15		Continent device; catheter for continent stoma. **Maximum of one (1) allowed per client per month.**
A5093	$1.95		Ostomy accessory, convex insert. **Maximum of 10 allowed per client per month.**
A5119	$10.51		Skin barrier; wipes, box per 50 (for ostomy only).
A5121	$7.46		Skin barrier, solid, 6 x 6 or equivalent, each, (for ostomy only).
A5122	$12.22		Skin barrier, solid, 8 x 8 or equivalent, each (for ostomy only).
A5123	N/A		***Discontinued for dates of service on and after October 1, 2003.***
A5126	$1.15		Adhesive or non-adhesive; disk or foam pad. **Maximum of 10 allowed per client per month.**
			UROLOGICAL SUPPLIES
			Billing provision limited to one (1) month's supply .
A4214	$1.49		Sterile saline or water, 30 cc vial. Included in nursing facility daily

HCPCS	October 1, 2003 Maximum Allowable	Modifier	Description
			Billing provision limited to one (1) month's supply .
A4310	$7.72		Insertion tray without drainage bag and without catheter (accessories only). **Maximum of 120 per client, per month.** Included in nursing facility daily rate. **Not allowed in combination with A4311, A4312, A4313, A4314, A4315, A4316, or A4354. Prior Authorization required.**
A4311	$14.84		Insertion tray without drainage bag with indwelling catheter, Foley type, two-way latex, with coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.). **Maximum of 3 allowed per client per month.** Included in nursing facility daily rate. **Not allowed in combination with code A4310 or A4338.**
A4312	$17.16		Insertion tray without drainage bag, with indwelling catheter, Foley type, two-way all silicone. **Maximum of 3 allowed per client per month**. Included in nursing facility daily rate. **Not allowed in combination with codes A4310 or A4344.**
A4313	$17.16		Insertion tray without drainage bag with indwelling catheter, Foley type, three-way for continuous irrigation. **Maximum of 3 allowed per client per month**. Included in nursing facility daily rate. **Not allowed in combination with code A4310 or A4346.**
A4314	$25.29		Insertion tray with drainage bag, with indwelling catheter, Foley type, two-way latex, with coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.). **Maximum of 3 allowed per client per month**. Included in nursing facility daily rate. **Not allowed in combination with codes A4310, A4311, A4338, A4354 or A4357.**
A4315	$26.39		Insertion tray with drainage bag, with indwelling catheter, Foley type, two-way all silicone. **Maximum of 3 allowed per client per month**. Included in nursing facility daily rate. **Not allowed in combination with code A4310, A4312, A4344, A4354 or A4357.**
A4316	$28.40		Insertion tray with drainage bag with indwelling catheter, Foley type, three-way for continuous irrigation. **Maximum of 3 allowed per client per month.** Included in nursing facility daily rate. **Not allowed in combination with code A4310, A4313, A4346, A4354, A4357, or K0280-K0281.**

HCPCS	October 1, 2003 Maximum Allowable	Modifier	Description
			Billing provision limited to one (1) month's supply .
A4320	$5.33		Irrigation tray with bulb or piston syringe, any purpose. **Maximum of 30 allowed per client per month**. Included in nursing facility daily rate. **Not allowed in combination with code A4322 or A4355**.
A4323	$8.78		Sterile saline irrigation solution, 1000 ml. Included in nursing facility daily rate.
A4324	$2.17		Male external catheter, with adhesive coating, each. **Maximum of 60 allowed per client per month.**
A4325	$1.80		Male external catheter, with adhesive strip, each. **Maximum of 60 allowed per client per month.**
A4326	$10.79		Male external catheter specialty type (e.g., inflatable, faceplate, etc.), each. **Maximum of 60 allowed per client per month**. Included in nursing facility daily rate.
A4330	$7.15		Perianal fecal collection pouch with adhesive, each. Included in nursing facility daily rate.
A4331	$3.18		Extension drainage tubing, any type, any length, with connector/adapter, for use with urinary leg bag or urostomy pouch, each. **Not to be used with Procedure Code A4358**. Included in nursing facility daily rate.
A4332	$0.12		Lubricant, individual sterile packet, for insertion of urinary catheter, each. Included in nursing facility daily rate.
A4335	$0.36		Diaper Doublers, each (age 3 and up). Included in nursing facility daily rate. **See expedited prior authorization criteria.** ***Replaces code 4621A.***
A4338	$12.26		Indwelling catheter; Foley type, two-way latex, with coating (Teflon, silicone, silicone elastomer, or hydrophilic, etc.), each. **Maximum of 3 allowed per client per month**. Included in nursing facility daily rate.

HCPCS	October 1, 2003 Maximum Allowable	Modifier	Description
			Billing provision limited to one (1) month's supply .
A4340	$31.75		Indwelling catheter; specialty type (e.g., coude, mushroom, wing, etc.), each. **Maximum of 3 allowed per client per month**. Included in nursing facility daily rate.
A4344	$16.02		Indwelling catheter, Foley type, two-way, all silicone, each. **Maximum of 3 allowed per client, per month.** Included in nursing facility daily rate.
A4346	$16.65		Indwelling catheter, Foley type, three-way for continuous irrigation, each. **Maximum of 3 allowed per client, per month**. Included in nursing facility daily rate.
4350A	N/A		***Discontinued for dates of service on and after October 1, 2003.***
A4351	$1.81		Intermittent urinary catheter; straight tip, with or without coating (Teflon, silicone, silocone elastomeric,or hydrophilic, etc.) each. **Maximum of 120 allowed per client per month**. **Replaces code 4350A.**
A4352	$6.42		Intermittent urinary catheter; coude (curved) tip with or without coating (Teflon, silicone, silicone elastomer or hydrophilic, etc.), each. **Maximum of 120 allowed per client per month**. **Replaces code 4350A.**
A4353	$7.00		Intermittent urinary catheter, with insertion supplies. **Maximum of 120 allowed per client per month**. Included in nursing facility daily rate. **Not allowed in combination with A4310, A4351-A4352. Prior Authorization required.**
A4354	$10.03		Insertion tray with drainage bag but without catheter. **Maximum of 3 allowed per client per month. Not allowed in combination with A4310 or A4357. Prior Authorization required.**
A4355	$8.91		Irrigation tubing set for continuous bladder irrigation through a three-way indwelling Foley catheter. Included in nursing facility daily rate. **Not allowed in combination with A4320, A4322.**
A4356	$38.79		External urethral clamp or compression device (not to be used for catheter clamp), each. **Maximum of two (2) allowed per client per year**. Included in nursing facility daily rate.

HCPCS	October 1, 2003 Maximum Allowable	Modifier	Description
			Billing provision limited to one (1) month's supply .
A4357	$9.70		Bedside drainage bag, day or night, with or without anti-reflux device, with or without tube, each. **Maximum of two (2) allowed per client per month**. Included in nursing facility daily rate. **Not allowed in combination with code A4314-A4316 or A4354.**
A4358	$6.45		Urinary drainage bag, leg or abdomen, vinyl, with or without tube, with straps, each. **Maximum of two (2) allowed per client per month**. Included in nursing facility daily rate. **Not allowed in combination with code A5113, A5114, or K0280.**
A4359	$30.07		Urinary suspensory without leg bag. **Maximum of two (2) allowed per client per month**. Included in nursing facility daily rate.
A4402	$1.60		Lubricant, per oz. Included in nursing facility daily rate. (For insertion of urinary catheters.)
A4521	$0.66		Adult sized incontinence product diaper, small size, each. **Age 19 and up. Maximum of 240 diapers purchased per client, per month**. **Medical exceptions to maximum quantity or age limitation require prior approval.** Included in nursing facility daily rate. **Not allowed in combination with any other disposable diaper or pant or rental reusable diaper or pant.** ***Replaces code 4620A.***
A4522	$0.72		Adult sized incontinence product diaper, medium size, each. **Age 19 and up. Maximum of 240 diapers purchased per client, per month**. **Medical exceptions to maximum quantity or age limitation require prior approval.** Included in nursing facility daily rate. **Not allowed in combination with any other disposable diaper or pant or rental reusable diaper or pant.** ***Replaces code 4625A.***
A4523	$0.88		Adult sized incontinence product diaper, large size, each. **Age 19 and up. Maximum of 240 diapers purchased per client, per month**. **Medical exceptions to maximum quantity or age limitation require prior approval.** Included in nursing facility daily rate. **Not allowed in combination with any other disposable diaper or pant or rental reusable diaper or pant.** ***Replaces code 4630A.***

HCPCS	October 1, 2003 Maximum Allowable	Modifier	Description
			Billing provision limited to one (1) month's supply .
A4525	$1.15		Adult sized incontinence product brief (pull-up), small size, each. **Age 6 and up. Maximum of 150 pieces allowed per adult, per month, per month. 300 allowed for ages 6-19.** Included in nursing facility daily rate. ***Not allowed in combination with any other disposable diaper or pant or rental reusable diaper or pant unless modifier 59 is used to designate daytime only usage. Replaces code 4797A.***
A4526	$1.15		Adult sized incontinence product brief (pull-up), medium size, each. **(age 6 and up). Maximum of 150 pieces allowed per adult, per month**. 300 allowed for ages 6-19. Included in nursing facility daily rate. **Not allowed in combination with any other disposable diaper or pant or rental reusable diaper or pant unless modifier 59 is used to designate daytime only usage. *Replaces code 4797A.***
A4527	$1.15		Adult sized incontinence product brief (pull-up), large size, each. **(age 6 and up). Maximum of 150 pieces allowed per adult, per month.** 300 allowed for ages 6-19. Included in nursing facility daily rate. **Not allowed in combination with any other disposable diaper or pant or rental reusable diaper or pant unless modifier 59 is used to designate daytime only usage**. ***Replaces code 4797A.***
A4528	$1.15		Adult sized incontinence product brief (pull-up), extra large size, each. **(age 6 and up). (age 6 and up). Maximum of 150 pieces allowed per adult, per month**. 300 allowed for ages 6-19. Included in nursing facility daily rate. **Not allowed in combination with any other disposable diaper or pant or rental reusable diaper or pant unless modifier 59 is used to designate daytime only usage. *Replaces code***
A4529	$0.31		Child sized incontinence product, diaper, small/medium size, each. **(3-18 years of age). Maximum of 300 diapers purchased per client per month. Medical exceptions to maximum quantity or age limitation require prior approval**. Included in nursing facility daily rate. **Not allowed in combination with any other disposable diaper or pant or rental reusable diaper or pant. *Replaces codes 4610A and 4611A.***

HCPCS	October 1, 2003 Maximum Allowable	Modifier	Description
			Billing provision limited to one (1) month's supply .
A4530	$0.65		Child sized incontinence product, diaper, large size, each. **(3-18 years of age). Maximum of 300 diapers purchased per client per month. Medical exceptions to maximum quantity or age limitation require prior approval.** Included in nursing facility daily rate. **Not allowed in combination with any other disposable diaper or pant or rental reusable diaper or pant.** ***Replaces code 4612A.***
A4531	$0.61		Child sized incontinence product, brief, small/medium size, each. (3-18 years of age). **Maximum of 150 allowed per client per month**. Included in nursing facility daily rate. **Not allowed in combination with any other disposable diaper or pant or rental reusable diaper or pant unless modifier 59 is used to designate daytime only usage.** ***Replaces codes 4790A & 4791A.***
A4532	$0.65		Child sized incontinence product, brief, large size, each. **(age 3 and up). Maximum of 150 allowed per client per month**. Included in nursing facility daily rate. **Not allowed in combination with any other disposable diaper or pant or rental reusable diaper or pant unless modifier 59 is used to designate daytime only usage.** ***Replaces code 4792A.***
A4533	$0.88		Youth sized incontinence product, diaper, each. **(3-18 years of age). Maximum of 300 allowed per client per month.** Included in nursing facility daily rate. **Not allowed in combination with any other disposable diaper or pant or rental reusable diaper or pant unless modifier 59 is used to designate daytime only usage.**
A4535	$0.65		Disposable liner/shield for incontinence, each. **(3 and up). Maximum of 240 allowed per client per month.** Included in nursing facility daily rate. **Not allowed in combination with any other disposable diaper or pant or rental reusable diaper or pant unless modifier 59 is used to designate daytime only usage.**
A4536	$8.46	NU	Protective underwear washable, any size, each. (Pant, reusable). **Maximum of 4 per client, per year (age 3 and up). Included in nursing facility daily rate. Modifier NU required**. ***Replaces code 4795A-1P*** **.**

HCPCS	October 1, 2003 Maximum Allowable	Modifier	Description
			Billing provision limited to one (1) month's supply .
A4536	$0.76	RR	Protective underwear washable, any size, each. (Pant, reusable). **Maximum of 150 pieces allowed per client, per month. (age 3 and up).** Included in nursing facility daily rate. **Not allowed in combination with any other disposable diaper or pant or rental, reusable diaper or pant. Modifier RR required.** ***Replaces code 4795A-RR.***
A4537	$13.64	NU	Underpad, reusable washable, any size (for bed purchase). **Limit 42 per year**. Included in nursing facility daily rate. **Not allowed in combination with code A4554 or A4537 (RR).** ***Replaces code 4521A 1P.***
A4537	$0.45	RR	Underpad, reusable washable, any size (for bed rental). **Limit 90 per month**. Included in nursing facility daily rate. **Not allowed in combination with code A4554 or A4537 (NU).** ***Replaces code 4521A RR.***
A4538	$0.75	RR	Diapers, cloth, reusable child's, any size, each **(age 3 and up). Maximum of 240 diapers allowed per client per month. Medical exceptions to maximum quantity or age limitation require prior approval.** Included in nursing facility daily rate. **Modifier required**. **Not allowed in combination with any other disposable diaper or pant or rental reusable diaper or pant.** ***Replaces codes 4616A-RR and 4640A-RR.***
A4554	$0.41		Disposable underpads for beds, all sizes (e.g., Chux's). **Maximum of 180 pieces allowed per client per month**. Included in nursing facility daily rate. **Not allowed in combination with code A4537 (NU) or A4537 (RR).**
A5102	$22.58		Bedside drainage bottle, with or without tubing, rigid or expandable, each. **Maximum of two (2) allowed per client per 6 months**. Included in nursing facility daily rate.
A5105	$40.76		Urinary suspensory, with leg bag, with or without tube. **Maximum of two (2) allowed per client per month.** Included in nursing facility daily rate. **Not allowed in combination with code A4358, A4359, A5112, A5113, A5114, or K0280**
A5112	$34.62		Urinary leg bag; latex. **Maximum of one (1) allowed per client per month**. Included in nursing facility daily rate. **Not allowed in combination with code A5113 or A5114**.

HCPCS	October 1, 2003 Maximum Allowable	Modifier	Description
			Billing provision limited to one (1) month's supply .
A5113	$4.70	RP	Leg strap; replacement only, latex, per set. Included in nursing facility daily rate. **RP modifier required**.
A5114	$8.94	RP	Leg strap, foam or fabric, replacement only, per set. Included in nursing facility daily rate. **RP modifier required.**
T1500	$2.73	NU	Diaper/incontinent pant, reusable/washable, any size, each. **(age 3 and up). Maximum of 36 diapers purchased per client per year. Medical exceptions to maximum quantity or age limitation require prior approval**. Included in nursing facility daily rate. **Modifier required.** ***Replaces code 4616A-1P and 4640A-1P.***
			BRACES, BELTS, AND SUPPORTIVE DEVICES
			Billing provision limited to one (1) month's supply .
A4490	$22.74		Surgical stocking above knee length, each. **Maximum of two (2) pair allowed per client per 6 months. (Enter 2 in the unit field for a pair.)**
A4495	$36.76		Surgical stocking thigh length, each. **Maximum of two (2) pair allowed per client per 6 months. (Enter 2 in the unit field for a pair.)**
A4500	$22.74		Surgical stocking below knee length, each. **Maximum of two (2) pair allowed per client per 6 months. (Enter 2 in the unit field for a pair.)**
A4510	$83.56		Surgical stocking full length, each. (Pantyhose style) **Maximum of two (2) pair allowed per client per 6 months.**
A4565	$10.32		Slings. **Maximum of two (2) allowed per client per year.**
A4570	$14.52		Splint. **Maximum of one (1) allowed per client per year.**
E0942	$19.85		Cervical head harness/halter. **Maximum of one (1) allowed per client per year**. Included in nursing facility daily rate.

HCPCS	October 1, 2003 Maximum Allowable	Modifier	Description
			Billing provision limited to one (1) month's supply .
E0943	$27.67		Cervical pillow. **Maximum of one (1) allowed per client per year.** Included in nursing facility daily rate.
E0944	$42.67		Pelvic belt/harness/boot. **Maximum of one (1) allowed per client per year**. Included in nursing facility daily rate.
E0945	$44.32		Extremity belt/harness. **Maximum of one (1) allowed per client per year**. Included in nursing facility daily rate.
L8210	65%		Gradient compression stocking, custom made. ***Replaces codes 4512A and 4513A.***
DECUBITUS CARE PRODUCTS			
			Billing provision limited to one (1) month's supply .
E0188	$26.43		Synthetic sheepskin pad. **Maximum of one (1) allowed per client per year**. Included in nursing facility daily rate.
E0189	$44.17		Lambswool sheepskin pad. **Maximum of one (1) allowed per client per year**. Included in nursing facility daily rate.
E0191	$8.49		Heel or elbow protector, each. **Maximum of four (4) allowed per client per year**. Included in nursing facility daily rate.
TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR (TENS) SUPPLIES			
			Billing provision limited to one (1) month's supply .
A4558	$5.45		Conductive paste or gel.
A4595	$28.81		TENS supplies, 2 lead, per month (includes electrodes (any type), conductive paste or gel, tape or other adhesive, adhesive remover, skin prep materials, batteries (9 volt or AA, single use or rechargeable), and a battery charger (if using rechargeable batteries). **Maximum of two (2) per month allowed with patient-owned 4-lead TENS unit.**

HCPCS	October 1, 2003 Maximum Allowable	Modifier	Description
			Billing provision limited to one (1) month's supply .
A4630	$6.26		Replacement batteries for medically necessary transcutaneous electrical nerve stimulator (TENS) owned by patient.
A4556	$10.32		Electrodes, pair. ***Replaces codes 0119E, 0121E and 0123E.***
A4557	$17.49		Lead wires (e.g., apnea monitors, TENs) per pair. **Replaces code 0124E.**

MISCELLANEOUS SUPPLIES

			Billing provision limited to one (1) month's supply .
A6440	$11.38		Zinc paste impregnated bandage, non-elastic, knitted/woven, width greater than or equal to three inches and less than five inches, per roll (at least 10 yards, unstretched). ***Replaces code 4460A.***
A6410	$0.39		Eye pad, sterile, each. **Maximum of 20 allowed per client per month.** Included in nursing facility daily rate. ***Replaces code 4529A.***
A6411	$2.35		Eye pad, non-sterile, each. **Maximum of 1 allowed per client per month**. Included in nursing facility daily rate. ***Replaces code 4530A.***
A4927	$12.00		Gloves, non sterile, **per box of 100**. Included in nursing facility daily rate. ***Replaces code 4555A.***
A4930	$0.77		Gloves, sterile, per pair. Included in nursing facility daily rate. ***Replaces code 4560A.***
E1399	$3.85		Durable Medial Equipment Miscellaneous.("Sharps" disposal container for home use, up to one gallon size, each. **Limit two per month**. **Included in nursing facility daily rate. Replaces code 4580A.** ***EPA# 870000863 must be used when billing this code.)***
E1399	$8.91		Durable Medial Equipment Miscellaneous. (Lice comb, such as LiceOut™ LeisMeister™ or combs of equivalent quality and effectiveness. **Maximum of one (1) allowed, per client, per year**. **Included in nursing facility daily rate. Replaces code 0172A.** ***EPA# 870000861 must be used when billing this code.)***

HCPCS	October 1, 2003 Maximum Allowable	Modifier	Description
			Billing provision limited to one (1) month's supply .
E1399	$11.98		Durable Medial Equipment Miscellaneous. (Non-toxic gel such as LiceOut™ for use with lice combs, per 8 oz bottle. **Maximum of (1) bottle allowed per client per year.** Included in nursing facility daily rate. ***Replaces code 0173A). EPA#870000862 must be used when billing this code.)***
E1399	65%		Durable Medial Equipment Miscellaneous. (Other medical supplies not listed). ***Prior authorization is required. Replaces code 4570A*** **.**

Other discontinued codes:

0116E	**Discontinued due to no utilization and may be billed under code E1399.**
0118E	**Discontinued and may be billed under code E1399.**
0126E	**TENs stand alone replacement battery charger, each. Now may be billed under E1399 with prior authorization. A4595 cannot be billed with this item.**
4991A	**Bilirubin light therapy supplies are now included in the reimbursement of the light.**
0936E	**Continuous passive motion softgoods kit has been incorporated into the rental of the CPM device.**

Billing

What is the time limit for billing? [Refer to WAC 388-502-0150]

MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards for: 1) initial claims; and 2) resubmitted claims.

- **Initial Claims**

  ✓ MAA requires providers to obtain an ICN for an **initial claim** within 365 days from any of the following:

  - The date the provider furnishes the service to the eligible client;
  - The date a final fair hearing decision is entered that impacts the particular claim;
  - The date a court orders MAA to cover the services; or
  - The date DSHS certifies a client eligible under delayed[1] certification criteria.

  ✓ MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

  - DSHS certification of a client for a retroactive[2] period; or
  - The provider proves to MAA's satisfaction that there are extenuating circumstances.

---

[1] **Delayed Certification -** According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

[2] **Retroactive Certification -** According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill MAA for the service.

- **Resubmitted Claims**

  Providers may **resubmit, modify, or adjust** any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

  ☞ **Note:** MAA does not accept any claim for resubmission, modification, or adjustment after the time period listed above.

- The time periods do not apply to overpayments that the provider must refund to DSHS. After the time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  ✓ The provider fails to meet these listed requirements; and
  ✓ MAA does not pay the claim.

What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee**.**

☞ **Exception:** If billing Medicare Part B crossover claims, bill the amount submitted to Medicare.

How do I bill for services provided to Primary Care Case Management (PCCM) clients?

When billing for services provided to PCCM clients:

- Enter the referring physician or PCCM name in field 17 on the HCFA-1500 claim form; and
- Enter the seven-digit, MAA-assigned identification number of the PCCM who referred the client for the service(s). If the client is enrolled with a PCCM and the PCCM referral number is not in field 17a when you bill MAA, the claim will be denied.

How do I bill for clients who are eligible for Medicare and Medicaid?

If a client is eligible for both Medicare and Medicaid (otherwise known as "dually-eligible"), **you must first submit a claim to Medicare and accept assignment within Medicare's time limitations**. MAA may make an additional payment after Medicare reimburses you.

- If Medicare pays the claim, the provider must bill MAA within six months of the date Medicare processes the claim.
- If Medicare denies payment of the claim, MAA requires the provider to meet MAA's initial 365-day requirement for initial claim (see page H.1).
- Codes billed to MAA must match codes billed to Medicare when billed as a Medicare Part B crossover claim.

Medicare Part B

Benefits covered under Part B include: **Physician, outpatient hospital services, home health, durable medical equipment, and other medical services and supplies** not covered under Part A.

When the words *"This information is being sent to either a private insurer or Medicaid fiscal agent,"* appear on your Medicare remittance notice, it means that your claim has been forwarded to MAA or a private insurer for deductible and/or coinsurance processing.

If you have received a payment or denial from Medicare, but it does not appear on your MAA Remittance and Status Report (RA) within 45 days from Medicare's statement date, you should bill MAA directly.

- If Medicare has made payment, and there is a balance due from MAA, you must submit a HCFA-1500 claim form (with the "XO" indicator in field 19). Bill only those lines Medicare paid. Do not submit paid lines with denied lines. This could cause a delay in payment or a denial.

- If Medicare denies services, but MAA covers them, you must bill on a HCFA-1500 claim form (without the "XO" indicator in field 19). Bill only those lines Medicare denied. Do not submit denied lines with paid lines. This could cause a delay in payment or a denial.

- If Medicare denies a service that requires prior authorization by MAA, MAA will waive the prior authorization requirement but will still require authorization. Authorization or denial of your request will be based upon medical necessity.

☞ **Note:**

- ✓ Medicare/Medicaid billing claims must be received by MAA within six (6) months of the Medicare EOMB paid date.
- ✓ A Medicare Remittance Notice or EOMB must be attached to each claim.

Payment Methodology – Part B

- MMIS compares MAA's allowed amount to Medicare's allowed amount and selects the lesser of the two. (If there is no MAA allowed amount, we use Medicare's allowed amount.)

- Medicare's payment is deducted from the amount selected above.

- If there is *no* balance due, the claim is denied because Medicare's payment exceeds MAA's allowable.

- If there *is* a balance due, payment is made towards the deductible and/or coinsurance up to MAA's maximum allowable.

MAA cannot make direct payments to clients to cover the deductible and/or coinsurance amount of Part B Medicare. MAA *can* pay these costs to the provider on behalf of the client when:

1) The provider accepts assignment; and

2) The total combined reimbursement to the provider from Medicare and Medicaid does not exceed Medicare or Medicaid's allowed amount, whichever is less.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's Medical Identification card. An insurance carrier's time limit for claim submissions may be different from MAA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you haven't received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement or EOB;
- If rebilling, also attach a copy of the MAA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the *Comments* field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on MAA's website at http://maa.dshs.wa.gov, downloadable files link, or by calling the Coordination of Benefits Section at 1-800-562-6136.

What records must be kept? [Refer to WAC 388-502-0020]

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

  ☞ **Note:** In addition to the above list, keep any specifically required forms for the provision of DME.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, for at least six years from the date of service or more if required by federal or state law or regulation.

A provider may contact MAA with questions regarding its programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs.
[Refer to WAC 388-502-0020 (2)]

How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

Important!

General Guidelines:

- **Use only the original preprinted red and white HCFA-1500 claim forms** (version 12/90 or later, preferably on 20# paper). This form is designed specifically for optical character recognition (OCR) systems. The scanner cannot read black and white (copied, carbon, or laser-printer generated) HCFA-1500 claim forms.

- **Do not use red ink pens, highlighters, "post-it notes," stickers, or correctional tape or fluid** anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process. Vital data will not be recognized. Do not write or use stamps or stickers that say, "REBILL," "TRACER," or "SECOND SUBMISSION" on claim form.

- **Use standard typewritten fonts** that are 10 c.p.i (characters per inch).
  Do not mix character fonts on the same claim form. Do not use italics or script.

- **Use upper case** (capital letters) for all alpha characters.

- **Use black** printer ribbon, ink-jet, or laser printer cartridges. Make sure ink is not too light or faded.

- **Ensure all the claim information is entirely contained within the proper field** on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.

- **Place only six detail lines on each claim form**. MAA does not accept "continued" claim forms. If more than six detail lines are needed, use additional claim forms.

- **Show the total amount for each claim form separately**. Do not indicate the entire total (for all claims) on the last claim form; **total each claim form**.

Field Description/Instructions

1a. **Insured's I.D. No.**: Required. Enter the MAA Patient (client) Identification Code (PIC). This information is obtained from the client's current monthly Medical Identification card and consists of the client's:

a) First and middle initials (a dash [-] *must* be used if the middle initial is not available).
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c) First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tie breaker.
d) An alpha or numeric character (tie breaker).

For example:

1. Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
2. John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B.
3. A PIC for Mary C. Johnson's newborn baby would look like this: MC010667JOHNSB and would show a **B** indicator in *field 19.*

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the MAA client.

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the MAA client who has received the services you are billing for (the person whose name is in *field 2*.)

9. **Other Insured's Name**: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, and Medicare, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related To**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and MAA pays as payor of last resort.

11a. Insured's Date of Birth: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

11b. Employer's Name or School Name: Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. Insurance Plan Name or Program Name: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. Is There Another Health Benefit Plan?: Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. If **11d.** is left blank, the claim may be processed and denied in error.

17. Name of Referring Physician or Other Source: When applicable, enter the referring physician or Primary Care Case Manager name.

17a. I.D. Number of Referring Physician: When applicable, 1) enter the seven-digit, MAA-assigned identification number of the provider who *referred or ordered* the medical service; OR 2) when the Primary Care Case Manager (PCCM) referred the service, enter his/her seven-digit identification number here. If the client is enrolled in a PCCM plan and the PCCM referral number is not in this field when you bill MAA, the claim will be denied.

19. Reserved For Local Use: When applicable, enter indicator **B** to indicate *Baby on Parent's PIC*. Please specify *twin A or B, triplet A, B, or C* here. **If you have more than one EPA number to bill, place both numbers here.**

21. Diagnosis or Nature of Illness or Injury: When applicable, enter the appropriate diagnosis code(s) in areas 1, 2, 3, and 4. A valid ICD-9-CM code will be required. MAA no longer allows the use of an unspecified/ dummy diagnosis code such as V58.9.

22. **Medicaid Resubmission**: When applicable. If the billing is resubmitted beyond the 365-day billing time limit, you must enter the ICN to verify that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.)

23. **Prior Authorization/EPA Number**: When applicable. If the service or equipment you are billing for requires authorization, enter the nine-digit number assigned to you.

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

MAA does not accept "continued" claim forms. Each claim form must be totaled separately.

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., October 4, 2003 = 100403). **Do not use slashes, dashes, or hyphens to separate month, day, year.**

24B. **Place of Service**: Required. These are the only appropriate code(s) for this billing instruction:

Code	To Be Used For
12	Client's residence
32	Nursing facility
31	Skilled nursing facility
99	Other

24C. **Type of Service**: Not required.

24D. **Procedures, Services or Supplies**
HCPCS: Required. Enter the appropriate Centers for Medicare and Medicaid (CMS) (formerly known as HCFA) Common Procedure Coding System (HCPCS) procedure code for the services being billed.
MODIFIER: When appropriate enter a modifier.

24E. **Diagnosis Code**: Required. Enter the ICD-9-CM diagnosis code related to the procedure or service being billed (for each item listed in 24D). A diagnosis code is required for each service or line billed. Enter the code exactly as shown in ICD-9-CM. A valid ICD-9-CM code is required. MAA no longer allows the use of an unspecified/dummy diagnosis code such as V58.9.

24F. **$ Charges**: Required. Enter your usual and customary charge for the service performed. If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax. Sales tax is automatically calculated by the system and included with your remittance amount.

24G. **Days or Units**: Required. Enter the total number of days or units (up to 999) for each line. These figures must be whole units.

25. **Federal Tax I.D. Number: Leave this field blank.**

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, i.e., a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

MAA does not accept "continued" claim forms. Each claim form must be totaled separately.

29. **Amount Paid**: If you receive an insurance payment or client-paid amount, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify the source in *field 10d*. Do not use dollar signs or decimals in this field or put Medicare payment here.

30. **Balance Due**: Required. Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Phone #**: Required. Put the *Name, Address,* and *Phone #* on all claim forms.

P.I.N. #: Required. Enter the individual provider number assigned to you by MAA.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

1. MEDICARE ( ) (Medicare #) | MEDICAID (X) (Medicaid #) | CHAMPUS ( ) (Sponsor's SSN) | CHAMPVA ( ) (VA File #) | GROUP HEALTH PLAN ( ) (SSN or ID) | FECA BLK LUNG ( ) (SSN) | OTHER ( ) (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): AE 071342 ALLEN A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): ALLEN, ALLON E.

3. PATIENT'S BIRTH DATE MM DD YY: 07 13 42 | SEX M ( ) F (X)

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 606 CELERY AVENUE

6. PATIENT RELATIONSHIP TO INSURED: Self ( ) Spouse ( ) Child ( ) Other ( )

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN | STATE: WA

8. PATIENT STATUS: Single ( ) Married ( ) Other ( )

CITY | STATE

ZIP CODE: 98000 | TELEPHONE (Include Area Code): ( )

Employed ( ) Full-Time Student ( ) Part-Time Student ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ( ) NO (X)

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M ( ) F ( )

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M ( ) F ( )

b. AUTO ACCIDENT? YES ( ) NO (X) PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ( ) NO (X)

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ( ) NO (X) *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY | ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: DR. MAYTOWN

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 8103384

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ( ) NO ( ) $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 344.0
2. 788.3
3.
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1	01 31 03	01 31 03	12		A4375		344.0	1884	1				24.00
2													
3													
4													
5													
6													

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN ( ) EIN ( )

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ( ) NO (X)

28. $ TOTAL CHARGE: 1884

29. $ AMOUNT PAID:

30. $ BALANCE DUE: 1884

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

3/15/03

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

UPTOWN MEDICAL SUPPLY
13 ROSE STREET
UPTOWN, WA 98000 (206) 555-1111

PIN# 6011845 GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Common Questions Regarding Medicare Part B/ Medicaid Crossover Claims

Q: Why do I have to mark "XO," in box 19 on crossover claim?

A: The "XO" allows our mailroom staff to identify crossover claims easily, ensuring accurate processing for payment.

Q: What fields do I use for HCFA-1500 Medicare information?

A:

In Field:	**Please Enter:**
19	an "XO"
24K	Medicare's allowed charges
29	Medicare's total deductible
30	Medicare's total payment
32	Medicare's EOMB process date, and the third-party liability amount

Q: When I bill Medicare denied lines to MAA, why is the claim denied?

A: Your bill is not a crossover when Medicare denies your claim or if you are billing for Medicare-denied lines. The Medicare EOMB must be attached to the claim. Do not indicate "XO."

Q: How do my claims reach Medicaid after I've sent them to Medicare?

A: After Medicare has processed your claim, and if Medicare has allowed the services, in most cases Medicare will forward the claim to MAA for any supplemental Medicaid payment. When the remarks code is, *"MA07-The claim information has also been forwarded to Medicaid for review*," it means that your claim has been forwarded to MAA.

Q: What if my claim(s) does not appear on the Remittance Advice and Status Report?

A: If **Medicare has paid** and the Medicare crossover claim does not appear on the MAA Remittance Advice and Status Report (RA) within 45 days of the Medicare statement date, you should bill MAA the *paid lines* on the HCFA-1500 claim form **with** an "XO" in box 19.

If **Medicare denies** a service, bill MAA the *denied lines*, using the HCFA-1500 claim form **without** an "XO" on the claim.

REMEMBER! Attach a copy of Medicare's EOMB. You must submit your claim to MAA within six months of the Medicare statement date if Medicare has **paid** or 365 days from date of service if Medicare has **denied**.

☞ **Note:** Claims billed to MAA with payment by Medicare must be submitted with the same procedure code used to bill Medicare.

How to Complete the HCFA-1500 Claim Form for Medicare Part B/Medicaid Crossovers

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

Important!

General Guidelines:

- **Use only the original preprinted red and white HCFA-1500 claim forms** (version 12/90 or later, preferably on 20# paper). This form is designed specifically for optical character recognition (OCR) systems. The scanner cannot read black and white (copied, carbon, or laser-printer generated) HCFA-1500 claim forms.

  If you need preprinted red and white HCFA-1500 claim forms, **call 1-800-562-6188.**

- **Do not use red ink pens, highlighters, "post-it notes," stickers**, **or correction tape or fluid** anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process. Vital data will not be recognized. Do not write or use stamps or stickers that say, "REBILL," "TRACER," or "SECOND SUBMISSION" on claim form.

- **Use standard typewritten fonts** that are 10 c.p.i (characters per inch).
  Do not mix character fonts on the same claim form. Do not use italics or script.

- **Use upper case** (capital letters) for all alpha characters.

- **Use black** printer ribbon, ink-jet, or laser printer cartridges. Make sure ink is not too light or faded.

- **Ensure all the claim information is entirely contained within the proper field** on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.

- **Place only six detail lines on each claim form**. MAA does not accept "continued" claim forms. If more than six detail lines are needed, use additional claim forms.

- **Show the total amount for each claim form separately**. Do not indicate the entire total (for all claims) on the last claim form; **total each claim form**.

The HCFA-1500 claim form, used for Medicare/Medicaid Benefits Coordination, cannot be billed electronically.

FIELD DESCRIPTION

1a. **Insured's I.D. No.**: Required. Enter the MAA Patient Identification Code (PIC), not the insured's Medicare number. This information is obtained from the client's current monthly Medical Identification card and consists of the client's:

- First and middle initials (a dash [-] *must* be used if the middle initial is not available).
- Six-digit birthdate, consisting of *numerals only* (MMDDYY).
- First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
- An alpha or numeric character (tiebreaker).

For example:

- ✓ Mary C. Johnson's PIC looks like this: MC010633JOHNSB.
- ✓ John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100226LEE B.

2. **Patient's Name**: Required. Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).

3. **Patient's Birthdate**: Required. Enter the birthdate of the MAA client.

4. **Insured's Name (Last Name, First Name, Middle Initial)**: When applicable. If the client has health insurance through employment or another source (e.g., private insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the client are the same - then the word *Same* may be entered.

5. **Patient's Address**: Required. Enter the address of the MAA client who has received the services you are billing for (the person whose name is in *field 2*).

9. **Other Insured's Name**: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, or private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, Medicare, Indian Health, PCCM, Healthy Options, PCOP, etc., are inappropriate entries for this field.

10. **Is Patient's Condition Related To**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

11. **Insured's Policy Group or FECA (Federal Employees Compensation Act) Number**: Primary insurance. When applicable. This information applies to the insured person listed in *field 4*. Enter the insured's policy and/or group number and his/her social security number. The data in this field will indicate that the client has other insurance coverage and MAA pays as payor of last resort.

11a. **Insured's Date of Birth**: Primary insurance. When applicable, enter the insured's birthdate, if different from *field 3*.

11b. **Employer's Name or School Name**: Primary insurance. When applicable, enter the insured's employer's name or school name.

11c. **Insurance Plan Name or Program Name**: Primary insurance. When applicable, show the insurance plan or program name to identify the primary insurance involved. *(Note: This may or may not be associated with a group plan.)*

11d. **Is There Another Health Benefit Plan?:** Required if the client has secondary insurance. Indicate *yes* or *no*. If yes, you should have completed *fields 9a.-d*. If the client has insurance, and even if you know the insurance will not cover the service you are billing, you must check *yes*. **If 11d. is left blank, the claim may be processed and denied in error.**

19. **Reserved For Local Use - Required. When Medicare allows services, enter *XO* to indicate this is a crossover claim.**

22. **Medicaid Resubmission**: When applicable. If this billing is being resubmitted more than six (6) months from Medicare's paid date, enter the Internal Control Number (ICN) that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the Remittance and Status Report.) Also enter the three-digit denial Explanation of Benefits (EOB).

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

24A. **Date(s) of Service**: Required. Enter the "from" and "to" dates using all six digits for each date. Enter the month, day, and year of service numerically (e.g., October 4, 2003 = 100403). **Do not use slashes, dashes, or hyphens to separate month, day, or year (MMDDYY).**

24B. **Place of Service**: Required. These are the only appropriate code(s) for this billing instruction:

Code	To Be Used For
12	Client's residence
32	Nursing facility
31	Skilled nursing facility
99	Other

24C. **Type of Service**: Not required.

24D. **Procedures, Services or Supplies HCPCS**: Required. Enter the appropriate Centers for Medicare and Medicaid (CMS) (formerly known as HCFA) Common Procedure Coding System (HCPCS) procedure code for the services being billed.
MODIFIER: When appropriate enter a modifier.

24E. **Diagnosis Code**: Enter appropriate diagnosis code for condition.

24F. **$ Charges**: Required**. Enter the amount you billed Medicare for the service performed.** If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field. Do not add sales tax.

24G. **Days or Units**: Required. Enter the number of units billed and paid for by Medicare.

24K. **Reserved for Local Use**: Required. Use this field to show Medicare allowed charges. Enter the Medicare allowed charge on each detail line of the claim (see sample).

26. **Your Patient's Account No.**: Not required. Enter an alphanumeric ID number, for example, a medical record number or patient account number. This number will be printed on your Remittance and Status Report under the heading *Patient Account Number*.

27. **Accept Assignment**: ***Required***. Check **yes.**

28. **Total Charge**: Required. Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: Required. Enter the Medicare Deductible here. Enter the amount as shown on Medicare's Remittance Notice and Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA-1500 claim forms (see field 24) and calculate the deductible based on the lines on each form. **Do not include coinsurance here.**

30. **Balance Due**: Required. Enter the Medicare Total Payment. Enter the amount as shown on Medicare's Remittance Notice or Explanation of Benefits. If you have more than six (6) detail lines to submit, please use multiple HCFA claim forms (see field 24) and calculate the Medicare payment based on the lines on each form. **Do not include coinsurance here.**

32. **Name and Address of Facility Where Services Are Rendered**: Required. Enter Medicare Statement Date ***and*** any Third-Party Liability Dollar Amount (e.g., auto, employee-sponsored, supplemental insurance) here, if any. If there is insurance payment on the claim, you must also attach the insurance Explanation of Benefits (EOB). **Do not include coinsurance here.**

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Phone #**: Required.

P.I.N. #: Required. Enter the individual provider number assigned to you by MAA, not your Medicare number.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

SAMPLE

APPROVED OMB-0938-0008

MEDICARE PART B CROSSOVER
(DO NOT FORGET TO ATTACH MEDICARE'S EOMB)

HEALTH INSURANCE CLAIM FORM

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): AE 071342 ALLEN A

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): ALLEN, ALLON E.

3. PATIENT'S BIRTH DATE MM DD YY: 07 13 42 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 606 CELERY AVENUE

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 98000 TELEPHONE (Include Area Code): ( )

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: DR. MAYTOWN

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 8103384

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE: XO

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES:

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 344.0
2. 788.3
3.
4.

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

24. A DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 01	31	03	01	31	03	12		A4314		344.0	2400	1				24.00
2																
3																
4																
5																
6																

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.:

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. $ TOTAL CHARGE: 2400

29. $ AMOUNT PAID: 1000

30. $ BALANCE DUE: 1400

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

3/15/03

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

UPTOWN MEDICAL SUPPLY
13 ROSE STREET
UPTOWN, WA 98000 (206) 555-1111

PIN# 6011845 GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

Appendix [Refer to WAC 388-543-1400 (4) and WAC 388-543-2900 (1) (2)]

Reimbursement Methodology for MSE

- MAA determines rates for each category of MSE using either the:
  - ✓ Medicare fee schedule; or
  - ✓ Manufacturer's catalogs and commercial databases for price comparisons.
- MAA evaluates and updates the maximum allowable fees for MSE as follows:
  - ✓ MAA sets the maximum allowable fees for new MSE using one of the following:
    - ➢ Medicare's fee schedule; or
    - ➢ For those items without a Medicare fee, commercial databases to identify brands to make up MAA's pricing cluster. MAA establishes the fee for products in the pricing cluster by using the lesser of either:
      - ⇨ 85% of the average manufacturer's list price; or
      - ⇨ 125% percent of the average dealer cost.
  - ✓ All the brands for which MAA obtains pricing information make up MAA's pricing cluster. However, MAA may limit the number of brands included in the pricing cluster if doing so is in the best interests of its clients. MAA considers all of the following:
    - ➢ A client's medical needs;
    - ➢ Product quality;
    - ➢ Cost; and
    - ➢ Available alternatives.
- MAA updates the maximum allowable fees for MSE no more than once per year, unless otherwise directed by the legislature. MAA may update the rates for different categories of medical equipment at different times during the year.

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